STATE OF IDAHO 1930 ARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS State File No... CERTIFICATE OF DEATH Registration District No. 2 9 Local Registrar's No. Primary Registration Sistrict No. 2/ ution, give its name instead of street and number.) death occurred in a hospital or inst 2. FULL NAME. Residence. No... (If nonresident give city or town and State) (Usual place of abode) How long in U. S., if of foreign birth? Length of residence in city or town where death occurred. MOR. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS Single, Married, Widowed. 16. DATE OF DEATH SEX COLOR OR RACE or Divorced (write the word) (Month) 5a. If married, widowed, or givorced 17. I HEREBY CERTIFY, That I attended deceased from HUSBAND of (or) WIFE of that I last saw h.... alive or 6. DATE OF BIRTH (month, day and year) If LESS than 1 day, Days and that death occurred, on the date stated above, at..... The CAUSE OF DEATH\* was as follows: min. 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, \_\_\_\_\_(duration) \_\_\_\_\_yrs. \_\_\_\_mos. \_\_\_ business, or establishment in which employed (or employer) CONTRIBUTORY ..... (Secondary) (c) Name of employer ......yrs. .....mos. ..... 9. BIRTHPLACE (city or town) 18. Where was disease contracted (State or country) if not at place of death? ... 10. NAME OF FATEER Did an operation precede death?\_\_\_\_\_ Date of\_\_\_\_\_ Was there an autopsy? 11. BIRTHPLACE OF FATHER What test confirmed diagnosis? PARENTS (State or Country) (Signed) \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) 18. BIRTHPLACE OF MOTHER (city or town (State or Country) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Cremation, or Removal Date of Burial 14. Informant (Address) Registrar

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ORD ACTLY, PHYSICIANS statement of OCCUPA-	PLACE OF DEATH  County of City		BUREAU OF VITAL ST CERTIFICATE OF Registration District No	DO NOT WRITE IN THIS SPACE State File No. S(1) 125  Local Registrar's No. 4		
r RECORD ed EXACTLY, Exact statemen	2.	FULL NAME 2/2000 (a) Residence. No.	Lars	St.		
PERMANENT hould be stated y classified. E	L	(Usual place of abode) ength of residence in city or town where de		(If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.		
MAN be ssifie	8	PERSONAL AND STATISTIC	AL PARTICULARS    5. Single, Married, Widowed,	MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH		
ould clar	1	emel sut	or Divorced (write the word)	gan. 6 1930		
IS A PERMANENT AGE should be state properly classified.	(b.	a. If married, widowed, or divorced HUSBAND of (or) WIFE of	f	(Month) (Day) (Year)  17. I HEREBY CERTIFY, That I attended deceased from		
HIS Pe		DATE OF BIRTH (month, day and year) AGE Years Months	Days LLESS than 1 day,	that I last saw h Enve on 19 19 and that death occurred, on the date stated above, at m.		
NG INK—TH nlly supplied, that it may b	8.	OCCUPATION OF DECEASED  (a) Trade, profession, or	A Moin	The CAUSE OF DEATH* was as follows:		
INFADIN e careful rms, so the		(a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer	<b>V</b>	(duration) yrs, mos. ds.  CONTRIBUTORY (Secondary)		
H	9.	BIRTHPLACE (city or town) OV (State or country)	co, I daho	(duration) yrs. mos. ds.  18. Where was disease contracted if not at place of death?		
~ _ =		10. NAME OF FATHER	f.	Did an operation precede death? Date of		
PLAID nforms DEAT See	PARENTS	11. BIRTHPLACE OF FATHER (city or (State or Country)	town) Malad	Was there an autopsy?  What test confirmed diagnosis (Signed)  (Signed)  (M. D.		
WRITE m of i JSE OF portant	PA	12. MAIDEN NAME OF MOTHER	um Durand	, 19 (Address)		
it CAU		13. BIRTHPLACE OF MOTHER (city of (State or Country)	town) Salmon Cit	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
Every state (is very	14	(Address)	ho	19. Place of Burial, Cremation, or Removal  Occ. I dello  on-7 19 70		
N. B. should TION i	16	Filed Jan. 7, 1930.	I Sall- Registrar	29 Undertaker Sami Address Address Address Address		

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RECE. . LD FEB 1 2 1930 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No. County of Carrier. Registration District No..... Local Registrar's No. Primary Registration District No. 2006 (If death occurred in a hospital or institution, give its name instead of street and number.) FULL NAME..... (Usual place of abode) (If nonresident give city or town and State) Length of residence in city or town where death occurred. How long in U. S., if of foreign birth? mos. Yrs. mos. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS classifi 16. DATE OF DEATH a. SEX 5. Single, Married, Widowed, 4. COLOR OR RACE or Divorced (write the word) (Month) 5a. If married, widowed, or divorced HUSBAND of 17. I HEREBY CERTIFY, That I attended deceased from (or) WIFE of 6. DATE OF BIRTH (month, day and year) 7. AGE Years Months If LESS than 1 day. and that death occurred, on the date stated above, at 2. P. min. The CAUSE OF DEATH\* was as follows: OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer) CONTRIBUTORY .... (c) Name of employer (duration) yrs. mos. ds. 9. BIRTHPLACE (city or town) Where was disease contracted (State or country) if not at place of death? 10. NAME OF FATHER Did an operation precede death? \_\_\_\_\_\_ Date of\_\_\_\_\_ Was there an autopsy? ...... 11. BIRTHPLACE OF FATHER (city or town) What test confirmed diagnosis? (State or Country) ð \*State the DISEASE CAUSING DEATH, or in ceaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE OF MOTHER (city or town) (State or Country) Place of Burial, Cremation, or Removal Date of Burial Informant. (Address) Address Registrar

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STATE OF IDAHO RECEIVED MAR 5 - 1930 DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATE CERTIFICATE OF DEATH State File No. Registration District No..... Local Registrar's No... City of Primary Registration District No. 2/14 Exact statement (No. (a) Residence, No. St. (Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in (If nonresident give city or town and State) How long in U. S., if of foreign birth? mos. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 16. DATE OF COLOR OR RACE Single, Married. (Month) (Day) (Year) If married, widowed, or divorced HUSBAND of nded deceased from (or) WIFE of OF BIRTH (month, day and year) If LESS than 1 day, Days ...hrs. or 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work....., (b) General nature of industry, business, or establishment in which employed (or employer) (duration) CONTRIBUTORY (c) Name of employer (Secondary) (duration) \_\_\_\_ 9. BIRTHPLACE (city or 18. Where was disease contracted if not at place of death? (State or country) 10. NAME OF FAT Did an operation precede death Was there an automsy? \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE OF (State or Country 19. Place of Burial, Cremation, or Removal Date of Burial 20. Undertaker Address Registrar

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MAKGIN KESEKVED FOR BINDING. INK—THIS IS A PERMANENT RECORD. Id be carefully supplied. AGE should be stated EXACTLY. DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back.	Primary Registration District (No. Section 1)  (If death occurred in a hospital or institution, kive  2. FULL NAME  (a) Residence. No.  (Usual place of abode.)  Length of residence in city or town where death occured. yrs. mon.  PERSONAL AND STATISTICAL PARTICULARS  3. SEX	its name instead of street and number.)  St.  (If nonresident give city or town and State.) ds. How long in U. S. if of foreign birth? yrs. mos. ds.  MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  17. I HEREBY CERTIFY, That I attended deceased from  The 2 1 19 19 19 19 19 19 19 19 19 19 19 19 1
WRITE PLAINLY, WITH UNFADING N. B.—Every item of information about should state CAUSE OF Exact statement of	10. NAME OF FATHER (A. Herring  11. BIRTHPLACE OF FATHER (city or town) (State or Country)  12. MAIDEN NAME OF MOTHER (city or town) (State or County)  14. Informant (Address)  15. File 3 130 Registrar.	(Secondary)  (duration)  18. Where was disease contracted if not at place of death?  Did an operation precede death?  Was there an autopsy?  What test confirmed diagnosis?  (Signed)  19. Place of Burial, Cremation, or Removal  20. Undertaker  Address  Address  Address

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STATE OF IDAHO PHYSICIANS of OCCUPA-RECEIVED MAR 5- 1930 DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATE CERTIFICATE OF DEATH State File No.. County of Registration District No..... Local Registrar's No.... Primary Registration District No..... (If death occurred to a hospital or institution, give its har (a) Residence. (If nonresident give city or town and State) (Usual place of abode) How long in U. S., if of foreign birth? mos. Length of residence in city or town where death occurred. mos. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 16. DATE OF DEADY Single, Married, Widowed 8. SEX 4. COLOR OR BACE (Month) (Year) 5a. If married, widowed, or divorced HUSBAND of HERERY CERTIFY. That I attended deceased from (or) WIFE of 6. DATE OF BIRTH (month, day and year) 7. AGE Years Months Davs and that death occurred, on the date stated above, at..... HE OF DEATH\* was as follows: min. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in (duration) \_\_\_\_yrs. \_\_\_mos. \_\_\_ which employed (or employer) CONTRIBUTORY .... (c) Name of employer (Secondary) \_(duration) \_\_\_\_vrs. \_\_\_mos. 9. BIRTHPLACE (city or town) 18. Where was disease contracted (State or country) if not at place of death? ..... 10. NAME OF FATHE Did an operation precede death? Date of\_\_\_\_\_ Was there an autopsy? .. What test confirmed diagnosis 11. BIRTHPLACE OF FATHER (State or Country) 12. MAIDEN NAME OF MOTHE \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 13. BIRTHPLACE OF MOTHER (city or town). (State or Country) Clace of Burial, Cremation, or Removal Date of Burial Informant (Address) Address

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sequences (e. g. sepsis, tetanus) may be stated under the

Do not accept a certificate of death signed only by a midwife.

head of "Contributory."

21		STATE OF IDAH	HO	<u> </u>	
A G	RECEIVED MAR 10 1930	DEPARTMENT OF PUBLIC	C WELFARE	DO NOT WRITE IN THIS SPACE	
ප්පි	PLACE OF DEATH	BUREAU OF VITAL ST.	ATISTICS	0 60607	
	1900 lena	CERTIFICATE OF 1	DEATH	State File No	
PHYSICIANS	County of	Registration District No	30		
	City of Coeur of bless	Primary Registration District		Local Registrar's No. 35	
EECORD EXACTLY, act statemen				1	
RECORD   EXACT   Exact state	(If death occurr	(Noad in a hospital or institution, give its	name instead of street and	number.)	
73 Mai 1	Traff	Cont 19 th	, a , a	$\sim$	
REC ed EX Exact	2. FULL NAME	July 1 Tour	Was a second	•	
70/4	(a) Residence. No.	6-30 /3-	St	(If nonresident give city or town and State)	
ENT   stated d. Ex	(Usual place of abode) Length of residence in city or town where de	ath occurred. yrs. mos. ds.	How long in U. S., if	of foreign birth? yrs. mos. ds.	
<b>7 0</b>	PERSONAL AND STATISTIC	AL PARTICULARS	MEDICAL CERTIFICATE OF DEATH		
ERMAI uld be classifi	8. SEX 4. COLOR QR RACE 5. Single, Married, Widowed,		16. DATE OF DEAT	TH.	
ING PERI should fly cla	The state of	or Divorced (write the word)		Meh 4 1932	
Z ~ & >	dennee omice	1		(Month) (Day) (Year)	
<b>∩</b> ≪:	5a. If married, widowed, or divorced HUSBAND of		17. I HEREBY CERT	CIFY, That I attended deceased from	
BINDING IS A PE AGE shou properly c	(or) WIFE of			19 to March 4/ 19 20	
	6. DATE OF BIRTH (month, day and year)	mch 4, 1930	that I last saw h.co	March 4 193	
FOR THIS ed. ,	7. AGE Years Months	Days If LESS than 1 day,		d, on the date stated above, at Birth 10. Pm.	
_   == @.4	0 0	O hrs. or	The CAUSE OF DEA	2, 011 010 100 000 000 000 000 000 000 00	
SERVED 1 G INK—7 Iy supplie hat it may			Prematu		
RVE INK Supj t it i	8. OCCUPATION OF DECEASED		J. Lewson		
SER IG ] Ily hat cer	(a) Trade, profession, or particular kind of work	>		wherefore in the second series for the first commence of the second seco	
RGIN RESERVED UNFADING INK- be carefully suppi erms, so that it m n back of certifica	(b) General nature of industry,				
H ~ U	business, or establishment in			(duration)yrsmosds.	
GIN NFA NFA E car ms, s ms, s	which employed (or employer)		CONTRIBUTORY C	brond pasting uterus	
MARGIN TH UNFA ild be ca in terms, n on bach	(c) Name of employer		(Secondary)	2 months	
MA TTH ould sain on o	a pypmyry A GTI (day on town)	and Allens		ds. (duration)yrsmosds.	
MA NLY, WITH ttion should I'H in plain instruction	9. BIRTHPLACE (city or town) (State or country)	Socho	18. Where was diseas	e contracted death?	
	10. NAME OF FATHER 4	1	Did an operation prece		
LY ion H j	fust	/ Julia	Was there an autopsy	<b>~</b>	
	100		What test confirmed d	£	
PLAI forma DEA See	11. BIRTHPLACE OF FATHER (city of (State or Country)  12. MAIDEN-NAME OF MOTHER	r town)	<b>\</b>	Yacard & XIII and you	
	H H	eece	(Signed)	3- (080)	
WRITE item of i AUSE OF		$\mathcal{B}$	, 19	30 (Address) NCC	
F SE	mazie 0	Trun dage	ACTACA ALA TITUTA CH	CAUCING DEAGE on in deaths from VIOLENIE	
W Sign	18. BIRTHPLACE OF MOTHER (city	pr sown)	CAUSES, state (1)	CAUSING DEATH, or in deaths from VIOLENT MEANS AND NATURE OF INJURY, and (2)	
	(State or Country)	70.		L, SUICIDAL, or HOMICIDAL.	
fvery ate C very	14. Informant /	utula	19. Place of Burial, C	remation, or Removal Date of Burial	
	(Address)	d'ole	Toract &	enely 3/6 1930	
~ \ [=""	3,000	0 %	20. Undertaker	Address	
N. B. Should	$15.$ Filed $3/4$ , 1930 $\lambda$	y Sturges	(17/12/	none / las	
, zat	, ,	Registrar		110 my menous	
				/	

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	STATE OF IDAHO	DO NOT WRITE IN THIS SPACE
7777	TMENT OF PUBLIC WELFARE EAU OF VITAL STATISTICS	Canara
PLACE OF DEATH		State File No
County of	CERTIFICATE OF DEATH	
City of Alexander in the Control of	District No.	Local Registrar's No.
Q	gistration District No.	900
(No)	tal or institution, give its name instead	of street and number.)
2. FULL NAME Baby	arkens.	
(a) Residence. No.	1	<b>B.</b>
(Usual place of abode.)  Length of residence in city or town where death occured.		(If nonresident give city or town and State ag in U. S. if of foreign birth?
	8 80 PM 1	MEDICAL CERTIFICATE OF DEATH
PERSONAL AND STATISTICAL PARTICULAR  3. SEX 4. COLOR OR RACE 5. Single.		
8. SEX 4. COLOR OR RACE 5. Single, or Divorced	Married, Widowed, 16. DATE (write the word.)	March 26 L
may while se	marke	(Month) (Day) (Ye
5a. If married, widowed, or divorced HUSBAND of	17. I HERE	BY CERTIFY, That I attended deceased from
(or) WIFE of		6 10 3 10 3 2 6 11
6. DATE OF BIRTH (month, day and year)	that bead	mThous Still Down
7. AGE Years Months Days If	LESS than 1 day, and that	death occurred, on the date stated above, at
	*State the	DISEASE CAUSING DEATH, or in deaths from VIOI
8. OCCUPATION OF DECEASED (a) Trade, profession, or		DENTAL, SUICIDAL, or HOMICIDAL PF DEATH* was as follows:
particular kind of work		remotive original
(b) General nature of industry, business, or establishment in		
which employed (or employer)		
(6) Name of employer		
9. BIRTHPLACE (city or town)		(duration)yrs,mos,
(State or country)	CONTRIBUT	rory
(State or country)	(Secondar	
	17	(duration)yrsmos
10. NAME OF FATHER	Tees	(duration)yrs,mos
(State or country)	la. Where if not i	was disease contracted at place of death?
(State or country)  10. NAME OF FATHER  11. BIRTHPLACE OF FATHER (city or town)  (State or Country)	18. Where if not in Did an oper Was there is	(duration) yrsmos was disease contracted at place of death? ation precede death? an autopsy?
(State or country)  10. NAME OF FATHER  11. BIRTHPLACE OF FATHER (city or town)  (State or Country)  12. MAIDEN NAME OF MOTHER	18. Where if not in Did an oper Was there is What test	(duration) yrs. mos.  was disease contracted at place of death? Date of an autopsy?
(State or country)  10. NAME OF FATHER  11. BIRTHPLACE OF FATHER (city or town)  (State or Country)	18. Where if not in Did an oper Was there is	was disease contracted at place of death?
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(State or country)  10. NAME OF FATHER  11. BIETHPLACE OF FATHER (city or town)  (State or Country)  12. MAIDEN NAME OF MOTHER  13. BIETHPLACE OF MOTHER (city or town)  (State or County)  14.  Informant	Baugh  18. Where if not is provided in the pro	(duration) yrs. mos.  was disease contracted at place of death?  ation precede death?
(State or country)  10. NAME OF FATHER  11. BIRTHPLACE OF FATHER (city or town)  12. MAIDEN NAME OF MOTHER  13. BIRTHPLACE OF MOTHER (city or town)  (State or County)	Baugh  Baugh  18. Where if not is Did an oper Was there is What test (Signs)  19. Place of Mohal is the state of the state	(duration) yrs. mos.  was disease contracted at place of death?  ation precede death?  but Date of death  an autopsy?  confirmed diagnosis?  d) (Address)  f Burial, Cremation, or Removal Date of Burial  Confirmed Date of Burial
(State or country)  10. NAME OF FATHER  11. BIRTHPLACE OF FATHER (city or town)  (State or Country)  12. MAIDEN NAME OF MOTHER  13. BIRTHPLACE OF MOTHER (city or town)  (State or Country)	Baugh  18. Where if not is provided in the pro	(duration) yrs. mos.  was disease contracted at place of death?  ation precede death? Date of  an autopsy?  confirmed diagnosis?  d)  (Address)  f Burial, Cremation, or Removal Date of Bu

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PLACE OF DEATH County of City of All All All All All All All All All Al	(210:	DO NOT WRITE IN THIS SPACE STATISTICS  BEATH  No. 2000  Local Registrar's No.
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8. SEX 4. COLOR OR RACE  5a. If married, widowed, or divorced HUSBAND of (or) WIFE of  6. DATE OF BIRTH (month, day and year)  7. AGE Years Months D  8. OCCUPATION OF DECEASED	5. Single, Married, Widowed, or Divorced (write the word.)	MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  (Month)  (Day)  (Year)  17. I HEREBY CERTIFY, That I attended deceased from 2 2 19 2 10 10 10 10 10 10 10 10 10 10 10 10 10
(a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer)  (e) Name of employer  9. BIRTHPLACE (city or town)	ay Falls	Compline broth (duration) yrs, mos.
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(State or County)  14.  Informant (Address)  15.  Filed 3 7 7 18 3	Bartier Register	19. Place of Burial, Cremation, or Removal  Address  20. Undertaker  Address

MARGIN RESERVED FOR BINDING

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midwife.

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BINDING IS A PERM AGE should properly class	8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)  5a. If married, widowed, or divorced HUSBAND of (or) WIFE of	16. DATE OF DEATH  (Month)  (Day)  (Year)  17. I HEREBY CERTIFY, That I attended deceased from
N RESERVED FOR BI FADING INK—THIS I carefully supplied. AG s, so that it may be pr ick of certificate.	6. DATE OF BIRTH (month, day and year)  7. AGE Years Months Days If LESS than 1 day, hrs. or min.  8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work.  (b) General nature of industry,	that I last saw h
ARGIN UNF be c terms on bac	business, or establishment in which employed (or employer)  (c) Name of employer	(duration)yrsmosds.  CONTRIBUTORY (Secondary)
PLAINLY, WITH nformation should DEATH in plain See instruction of	9. BIRTHPLACE (city or town)  10. NAME OF FATHER  (city or pown)  (State or Country)  11. BIRTHPLACE OF FATHER (city or pown)  (State or Country)	18. Where was disease contracted if not at place of death?  Did an operation precede death?  Was there an autopsy?  What test confirmed diagnosis?  (Signed)
WRITE em of i JSE OF portant.	12. MAIDEN NAME OF MOTHER City or town)	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
N. B.—Every ite should state CAU	14. Informant J. Richardson (Address) Rufut Islow  15. Filed -/O, 1930 Registrar	whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  19. Place of Burial, Cremation, or Removal  Purple Grant Land 2019 36  20 Undertaker  Address  Address

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STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

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DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

EATH ficate.	1. PLACE OF DEATH	TE OF DEATH State of Idaho BOARD OF HEALTH
e D	County of Alexander Primary Registration District No	File No. 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
0,4		St.) Registered No.
AUS	If death occurs away from	If death occurred in a hos-
arte C	usual residence, give facts called for under special in- formation.  2. FULL NAME	pital, institution or camp, give its NAME instead of street and number.
uld struction	PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
ORD 3 sho instr	3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID- OWED OR DIVORCED	
RECORD CIANS ab	m White (Write the word.)	16. DATE OF DEATH
NT ] YSICI	6. DATE OF BIRTH	(Month) (Day) (Year)
RMANE FLY, PH ry impo	(Month) (Day) (Year)	17. I HEREBY CERPIFY, That I attended deceased from
NG PE	7. AGE TILESS than 1 day	19,,, to ,
NDI)	héw many	that I last saw halive on
S BI	8. OCCUPATION	The CAUSE OF DEATH* was as follows:
	(a) Trade, profession or particular kind of work.	the set of
VED NK-	(b) General nature of in-	A + 11 / 3
SER 4G I GE e	dustry, business or estab- lishment in which employ- ed (or employer)	suce som
BEG ADIA	9. BIRTHPLACE	(Duration) Yrsds.
RGIN UNF.	(State or Country) Louisian Jon Jan.	Contributory(Secondary)
	10. NAME OF FATHER / / / / / / / / / / / / / / / / / / /	(Duration) yrsmosds.
MA WITH fully 8	11. BIRTHPLACE	(Signed) Ohas Darter M. D.
ILY, care assifi	OF FATHER	19 (Address) Markay
· VAL	(State or Country)	*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
E PLA	12. MAIDEN NAME OF MOTHER	
WRIT atton	18. BIRTHPLACE	18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Translents or Recent Residents.)
orms	OF MOTHER (State or Country)	At place In the of death yrs mos days. State yrs mos days
f inf at it	14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	Where was disease contracted if not at place of death?
o ii the	(Informant) 21.9/ Fullmus.	Former or usual residence
<>> ± € € € € € € € € € € € € € € € € € €	(Address) Roberts Star Proute	19. PZZCE OF ZURIAL OF REMOVAL DATE OF BURIAL
Ever 6	15. 7/	Dallinger Do Same 1619 30.
B. I. J.	Filed 7 1930 To Food Portoton	20. USDERTAKER / ADDRESS
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STATE OF IDAHO stated EXACTLY, PHYSICIANS RECE. VILL 1 1930 DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No. County Registration District No. Local Registrar's No. Primary Registration District No. 2086 PERMANENT RECORD of death occurred in a hospital or institution, give its name instead of street and number.) Residence. No.... (If nonresident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds (Usual place of abode) Length of residence in city or town where death occurred. mos. classified. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICU 16. DATE OF DEATH Single, Married, Widowed, COLOR OF RACE plnods or Divorced (write (Month) 5a. If married, widowed, or divorced 17. I HEREBY CERTIFY, That I attended deceased from AGE HUSBAND of (or) WIFE of 6. DATE OF BIRTH (month, day and year) than 1 day 7. AGE Years Months hat it may certificate. that death occurred, on the date ...hrs. or min. 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer should BIRTHPLACE (city or town) Where was disease contracted (State or country) if not at place of death? 10. NAME OF FATHER Did an operation precede death? OF DEATH Was there an autopsy? ..... PARENTS 11. BIRTHPLACE OF FATHER (city or town What test confirmed diagnosis? (State or Country) 12. MAIDEN NAME OF MOTHE \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 13. BIRTHPLACE OF MOTHER (city or town) Date of Burial 19. Place of Burial, Cremation, or Removal Informant (Address) 20. Undertaker Registrar

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CERTIFICATE OF DEATH State of Idaho BOARD OF HEALT Bureau of Vital Statistics Registration District No...... County of Primary Registration District No. File No..... Registered No..... If death occurs away from usual residence, give facts called for under special in-If death occurred in a hospital, institution or camp, give its NAME instead of street and number. 2. FULL NAME formation. PERSONAL AND STATISTICAL PARTICULARS 5. SINGLE, MARRIED, WID-4. COLOR OR RACE | WED OR DIVORCED 16. DATE OF DEATH the word.) 6. DATE OF BIRTH ecunst 17. / I HEREBY CERTIFY, That I attended deceased from IF LESS than 1 day 7. AGE how many 6 hrs. and that death occurred on the date stated above. 8. OCCUPATION (a) Trade, profession or particular kind of work..... (b) General nature of industry, business or establishment in which employed (or employer)..... Contributory. (State or Country (Secondary) 10. NAME OF (Signed) OF FATHER (Address) (State or Country) \*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal. 12. MAIDEN NAM OF MOTHER 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) 13. BIRTHPLACE OF MOTHER In the (State or Country) Where was disease contracted BEST OF MY KNOWLEDGE if not at place of death?.... Former or usual residence 15. Local Registrar SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

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_	STATE O	F IDAHO
	RECEIVED AUG 9 1980 DEPARTMENT OF	DO NOT WRITE IN THIS SPACE
*	BUREAU OF VI	- 84004
VIC.	PLACE OF DEATH	State File No.
PHYSICIAN	County of County	E OF DEATH
HY	City of Registration District No.	
A	Primary Registration D	strict No. 1004 Local Registrar's No. 205
×	(No. N. L. duk	<u>(1</u>
EXACTLY. classified. s on back.	death occurred in shospital or institution	n, give is name instead of street and number.)
ZAC Pariti	2. FULL NAME Vlanly Vardow	Jev
EX Clar	(a) Residence. No. 1206 Mo. 1314	St.
	(Usual place of abode.)  Length of residence in city or town where death occured. yrs. r	(If nonresident give city or town and State.) 104. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
ORD.  be stated  be properly c  instructions		THE PROPERTY OF THE OF THE OFFICE OFF
str.	PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
ING RECORD sould be may be 1 See ins	8. SEX 4. COLOR OR RACE 5. Single, Married, Wide or Divorced (write the w	
REC hould may	m- Uhi -	(Month) (Day) (Year)
BINDING VENT REC GE should nat it may ortant. Se	5a. If married, widowed, or divorced	HEREBY CERTIFY, That I attended deceas d from
牙足 一点	HUSBAND of (or) WIFE of	
4288	6. DATE OF BIRTH (month, day and year)	1900, to 19
FOR RMA		that I last saw h alive on 1930
ED I	hrs	or and that death occurred, on the date seated above, as
> < = = = = = = = = = = = = = = = = = =	min.	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
ER.	8. OCCUPATION OF DECEASED (a) Trade, profession, or	whether ACCIDENTAL, SUICIDAL, or HUMICIDAL. The CAUSE OF DEATH* was as follows:
RESER IS IS fully st plain t	particular kind of work	Premature berly
_ 88.42	(b) General nature of industry,	( 6 to O months forting)
RGII K - 1 F ca CUP	business, or establishment in which employed (or employer)	
4 Z T 40	(c) Name of employer	
	9. BIRTHPLACE (city or town)	ds.
Shoul Shoul OF D	(State or country)	CONTRIBUTORY
	10. NAME OF FATHER O	(Secondary)
UNFA rmation CAUSE statemen	Slauley / Fordon	duration)mosds.
Sta C	11. BIRTHPLACE OF FATHER (city or town) West	18. Where was disease contracted if not at place of death?
WITE f info state xact	(State or Country)	Did an operation precede death? Date of
WITT of inf state Exact	12. MAIDEN NAME OF MOTHER 0 - & ST	Was there an autopsy?
TLY, tem hould	Ovalue. V. Mile	What test confirmed diagnosis?
Sh st	13. BIRTHPLACE OF MOTHER (city or town) (State or County)	(Signed) M. D.
<b>₫</b> ₽	Ot a solution of	
C H	14. Informant Stanley R. Jarlan	19. Place of Burial, Cremation, or Removal Date of Burial
A STEE	(Address) /206 - Ino But St Baire	de Morris Hill Xemetry July 17 1030
MRITE PLAIN N. B.—Every ik	15. Filed 7-21 130 W& Rhodes	20. Undertaker Address
<i>-</i>	Filed A 190 Registra	Webseles M You Back the

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	0.1.1006	STATE OF ID	Ano		TAY MITTER ODACIE
i	RECEIVED JUL 2 1 1930	DEPARTMENT OF PUB	LIC WELFARE	DO NOT WRITE	E IN THIS SPACE
,	DY A CHACINE DE A MIX	BUREAU OF VITAL	STATISTICS	State File No	C 71397
_	PLACE OF DEATH	CERTIFICATE OF	DEATH	0.000	D 1100:
	ounty of B	Registration District No		*******	
Ci					al Registraris No
	1	rimary Registration District	erland,	ave.	$^{\prime}\mathcal{Y}_{\nu}$
	(If death occurs	d in hospital or institution, iv	e its name instead	of stret and number.)	10
2.	FULL NAME	1 dewy	Liefaul	<b>)</b> //	20N
	(a) Residence. No.	weiland	St		give city or town and State.
Ler	(Usual place of abode.) ngth of residence in city or town where de	eath occured. yrs. mos.	ds. How long	in U. S. if of foreign	birth? yrs. mos. C
	PERSONAL AND STATISTICAL	PARTICULARS		MEDICAL CERTIFICA	TE OF DEATH
	SEX 4. COLOR OR RACE		16. DATE OF	DEATH	
	Nale While	5. Single, Married, Widowed, or Divorced (write the word.)		June	/2 19 (Day) (Yea
		Julys		(Month)	(Day)
5 <b>a</b> .	. If married, widowed, or divorced HUSBAND of			Y CERTIFY, That I att	
<u> </u>	(or) WIFE of				, 19
6.	DATE OF BIRTH (month, day and year)	June 12-1930	that I last sav	w h alive on	19.
7.	AGE Years Months Da	If LESS than 1 day, hrs. or	and that de	ath occurred, on the da	te stated above, at
	0 0 0	)min.	*State the D	ISEASE CAUSING DEA	ATH, or in deaths from VIOL NATURE OF INJURY, and or HOMICIDAL.
8.	OCCUPATION OF DECEASED		whether ACCI	DENTAL, SUICIDAL, of DEATH* was as follows:	or HOMICIDAL.
	(a) Trade, profession, or particular kind of work	• •	$\mathbb{J}$	our au	and the same
		,	Page	caleure	Restle
	(b) General nature of industry, business, or establishment in which employed (or employer)				Joans
	(c) Name of employer		dea	the su or	
-	BIRTHPLACE (city or town)		-		yrsmos.
) °.	(State or country)	erly ddaho	CONTRIBUTO	JRY Z.	its side will
	10. NAME OF EACHER	, #	(Secondary		i)mos,
	Ode den	rey	. 11		• •
12	11. BIRTHPLACE OF FATHER (city or	(a) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c	if not at	place of death !	48 Data of
PARENTS	(State or Country)	Lower	Did an opera	tion precede death	Date of
MA.	12. MAIDEN NAME OF MOTHER	le Camp.		n autopsy?	
-	13. BIRTHPLACE OF MOTHER (city or	A Carlo	11	<b>E</b>	Elm
	(State or County)	daho.		/4, 19.30 (Addr	188) Kufert Ida
	8 /	7 10.	- 11	Burial, Cremation, or 1	Removal Date of Burial
14	Informant	wewy	- I alb	or Cline	leey 9/2//30
li .	(Address)	my Jaa,	-		Address
_		of A Care	20. Undertal	Kenp <sub>h</sub>	, , , , , , ,
11	6. Filed 7 - 1/1 - 1938 C	A Cutter Registrar.	8 C Ju	lucano bel	Terris Pa

STATE OF IDAHO

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35	RECEIVED AUG 1 4 1930 DEPARTMENT OF PUBLIC	C WELFARE DO NOT WRITE IN THIS SPACE	
털털	PLACE OF DEATH BUREAU OF VITAL ST	ATISTICS	
<u> </u>	CERTIFICATE OF	DEATH State File No	
Ħ'a	County of Registration District No.	6	
<b>"</b> #	City of Primary Registration District	No. 1016 Local Registrar's No. 13	
LY BE	100	•	
RECORD  REACTLY, PHYSICIAN  Exact statement of OCCUPA	(No. (If death occupied in a hospital or institution, give its	name instead of street and number.)	
	2. FULL NAME Soby, Still.	Bon	
<b>24</b> 53 .	The Distance of the Control of the C	7	
	(a) Residence. No	St. (If nonrealdent give city or town and State)	
PERMANENT hould be stated r classified. E	Length of residence in city or town where death occurred. yrs. mos. ds.	How long in U. S., if of foreign birth? yrs. mos. ds.	
MAN Sife	PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH	
ERM uld class	8. SEEL 4. COLOR OR MACE 5. Single, Married, Widowed, or Divorced (write the word)	16. DATE OF DEATH	
ING PER should rly cla	Ander Milo,	(Month) (Day) (Year)	
<c #="" #<="" th=""><td>5a. If married, widowed, or divorced HUSBAND of</td><td>17. I HEREBY CERTIFY, That I attended deceased from</td></c>	5a. If married, widowed, or divorced HUSBAND of	17. I HEREBY CERTIFY, That I attended deceased from	
BIN IS AGE	(or) WIFE of	area 1930 to Mark 1930	
~ ~ ~ ~ ~ ~	6. DATE OF BIRTH (month, day and year) Que 8-1930	sheet I had some her allow an	
FOR THIS ed.	7. AGE Years Months Days If LESS than 1 day,	and that death occurred, on the date stated above, at	
	hrs. or min.	The CAUSE OF DEATH was 12 follows:	
INK—TI Supplied H may	C OCCUPATION OF DECRARED	Stell down,	
8		The state of the s	
RESE DING efully of co	(a) Trade, profession, or particular kind of work		
	(h) General nature of industry, business, or establishment in	(duration)mosds.	
	which employed (or employer)	CONTRIBUTORY 2nd / Curry	
SE SE	(c) Name of employer	(Secondary)	
M H H H	9. BIRTHPLACE (city or town) shorhome &da	(duration) yrs. mos. ds.	
WYTH WYTH should plain iction	(State or country)	18. Where was disease contracted if not at place of death?	
7. FT	10. NAME OF FATHER	Did an operation precede death? Date of	
PLAINLY information DEATH	Justice Cannon	Was there an autopay?	
PLAINL nformatic DEATH See in	2 11. EURTHPLACE OF FATHER (city or town)	What test confirmed disgnosis?	
검실점		(Signed)M. D.	
	12. MATDEN NAME OF MOTHER /	19 (Aidean Flanting F	
WRITE item of 1 AUSE OF important	Wolt Burrer	*State the TITSHASH CATISING DEATH or in deaths from VIOLENT	
P de Sign	18. BIRTHPLACE OF MOTHER (city or town)	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, mate (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
	14. Tasta Comment	19. Place of Burial, Cremation, or Removal   Date of Burial	
OB-Ever state s ver	Informant Lesur Cannon	100 St. Lines of During, Or Stellmysh Date of Burner	
<b>~</b>	(Address)	shoshone Ida leng 9 80	
ON PAR PA	15. Fleet tiled 1930 C. L. tuller.	20. Undertaker Address	
N. B.	Registrar	WC Trustok Shoshong add	

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(If death occurred in a hospital or institution, give its name instead of street and number.) Infant Hill 2. FULL NAME..... Pocatello (a) Residence. No..... (Usual place of abode) (If nonresident give city or town and State) How long in U. S., if of foreign birth? Length of residence in city or town where death occurred PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed. 16. DATE OF DEATH or Divorced (write the word) 1930. August Female White (Day) (Year) 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of 1930. 6. DATE OF BIRTH (month, day and year) August 3, 7. AGE Years Months Days If LESS than 1 day, Stillborn The CAUSE OF DEATH\* was as follows UNFADING INK 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... None (b) General nature of industry, business, or establishment in Infant (duration) \_\_\_\_yrs. \_\_\_mos. which employed (or employer) ... CONTRIBUTORY (c) Name of employer (Secondary) .... (duration) Pocatello. Idaho. BIRTHPLACE (city or town). 18. Where was disease contracted if not at place of death? (State or country) 10. NAME OF FATHER Did an operation precede death Howard P. Hill Was there an autopsy? 11. BIRTHPLACE OF FATHER (city or town) What test confirmed Marknown (State or Country) Sterling. Tdaho. 12. MAIDEN NAME OF MOTHER Rhoda Homer \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE OF MOTHER (city or town)\_\_\_\_\_ (State or Country) Idaho. 19. Place of Burial Cremation, or Removal Mountain View Cemetery Howard P. Hill Date of Burial Informant.... Pocatello. Idaho. (Address) Pocatello. 20. Undertaker 8/5/30.

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Do not accept a certificate of death signed only by a

ro ·	OTHER OF THE	TIO.
PHYSICIANS	RECEIVED OCT 1 4 1930 STATE OF IDA	
55	PLACE OF DEATH BUREAU OF VITAL ST	DO NOT WINTE IN THIS STRUE
	County & See Salls CERTIFICATE OF	DEATH State File No
PH	Registration District No.	I and David and No. 200
. =	City of	No. 1085 Local Registrar's No. 162
ECORD EXACTLY, ict statemer	(No	)
RECORD EXACT	72 1-1 /	name instead of street and number.)
質問題	2. FULL NAME / JOSEPH CO	
7.5	(Usual place of abode)	
A sta	Length of residence in city or town where deth occurred. yrs. mos. ds.	How long in U. S., if of foreign birth? yrs. mos. ds.
NG PERMANENT tould be state g classified. I	PERSONAL AND STATISTICAL PARTICULARS	MEDICAL SERTIFICATE OF DEATH
RM IRM Ild	8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)	16. DATE OF DEATH
PE PE Pe Iy o	De male while Sugar	(Month) (Day) (Year)
BINDING IS A PE AGE shou properly c	5a. If married, widowed, or divorced  HUSBAND of  (or) WIFE of	17. I HEREBY CERTIFY, That I attended deceased from
BIP IS AGI proj	(or) WIFE of	, 19, to, 19,
OR HIS	6. DATE OF BIRTH (month, day and year)  7. AGE Years Months Days If LESS than 1 day,	that I last saw hadden shive on 19
Lay Lay	hrs. or	and that death occurred, on the date stated above, at
Fig. 5	min.	The CAUSE OF DEATH was as follows:
ER II	8. OCCUPATION OF DECEASED  (a) Trade, profession, or	
E E E	particular kind of work	Consorran section historius.
A R are	(b) General nature of industry, business, or establishment in	(duration)rsds.
RGII UNF be c erms	which employed (or employer)  (c) Name of employer	CONTRIBUTORY
A Paragraph of the para	(c) Name of employer	(Secondary)  (duration) yrsmosds.
Ising In	9. BIRTHPLACE (city or town) (State or country)	18. Where was disease contracted
sh Sh	10. NAME OF FATHER	if not at place of death?  Did an operation precede death?  Date of
fl.Y tion H i	al Dimons	Was there an autopsy?
LAÍN orma EAT See i	on 11. BIRTHPLACE OF FATHER (city or town)	What jest confirmed liagnosis?
PLA nform DE/ Sec	11: State or Country)  12. MAIDEN NAME OF MOTHER  12. MAIDEN NAME OF MOTHER	(Signed) A Dwight D. D.
re fr of	12. MAIDEN NAME OF MOTHER	Olyt. 6, 1930 (Address) July Jas
WRITE item of i AUSE OF	18. BIRTHPLACE OF MOTHER (city or town)	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
W] item AUSi	(State or Country)	CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL
d C	14. All Demons	19. Plage of Burial, Cremation, or Removal   Date of Burial
Later Ve	Informant. (Address)	1/1/1 / Del 5 19 30
	15. 20 FA . 70 FA	20. Undertaker
	Filed Oct, 4, 1930 Chaptery Smith Registrar	Tallande du Folla.
A TH		

MARGIN RESERVED FOR BINDING

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IGECORD.  ECORD.  and be stated by the property of the propert	PERSONAL AND STATISTICAL PARTICULARS  3. SEX   4. COLOR OR RACE   5. Sinde, Married, Widowed, or Differed (write the word.)	MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  (Month)  (Day)  (Year)
RESERVED FOR BINDING IS IS A PERMANENT RECALL AGE Shoupled. AGE shoupled terms, so that it mat ION is very important.	5a. If married, widowed, or divorced HUSBAND of (or) WIFE of  6. DATE OF BIRTH (month, day and year)  7. AGE Years Months Days If LESS than 1 day, hrs. or min.  8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work	that I last saw h/
MARGIN RESI ILY, WITH UNFADING INK-THIS I item of information should be carefully should state CAUSE OF DEATH in plain Exact statement of OCCUPATION	(c) Name of employer  9. BIRTHPLACE (city or town)  10. NAME OF FATHER  (State or country)  11. BIRTHPLACE OF FATHER (city or town)  (State or Country)  12. MAIDEN NAME OF MOTHER  (State or Country)  13. BIRTHPLACE OF MOTHER  (State or Country)	(duration) yrs. mos. ds.  CONTRIBUTORY (Secondary)  (duration) yrs. mos. ds.  18. Where was disease contracted if not at place of death?  Did an operation precede death?  Did an operation precede death?  Was there an autopy?  What test confirmed disgnosis?  (Signed) Address Oduse.
A O B WRITE PLAI N. B.—Every	14. Informant ingif blouglas.  (Address)  15. Filed //- 24, 130 W. Registrar.	Place of Burial, Cremation, or Removal  Phovins Hill Cenneley  193  20 Undertaker  Address  Sorse Help  Line of Burial  Pate of Burial  Address  Sorse Help  Line of Burial  Pate of Burial

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•	STATE OF IDA			
	RECEIVED DEC 2 0 1931 DEPARTMENT OF PUBL	IC WELFARE DO NOT WRITE IN THIS SPACE		
3	DIDEAT OF WITH S			
PHYSICIAN	PLACE OF DEATH			
IS:	County of A	72		
i 🙀	City of Leave Registration District No.	No. 2110 Local Registrar's No. 219		
P4	Primary Registration District	M6. Local Registrar's No.		
Þi	(No	)		
ACTL affied. back.	(If death occurred in a hospital or institution, give	its name instead of street and number.)		
EXACTLY. chassified. on back.	2. FULL NAME Baby - Skinner	٠		
EXACTI. chasified.	(a) Residence. No. 1 Ucon Julia	ho st.		
. (4)	(Usual place of abode.)  Length of residence in city or town where death occurred. yrs. mos.	(If nonresident tive city or town and State.) ds. How long in U. S. if of foreign birth? yrs. mos. ds.		
RD. be stated e properly instruction				
train at	PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH		
E s s s s s s s s s s s s s s s s s s s	SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word.)	16. DATE OF DEATH		
	Male white single	(Month) (Day) (Year)		
D FOR BINDING PERMANENT RECORD. Hed. AGE should be ns, so that it may be p ery important. See inst	5a. If married, widowed, or divorced			
Ê ta ± ta	HUSBAND of	17. I HEREBY CERTIFY, That I attended deceased from		
ANENAGE AGE	(er) WIFE of	, 19, te, 19, 19		
E C C E	6. DATE OF BIRTH (month, day and year)	that I last saw h alive on		
FOR d. A. A. so t	7. AGE Years Months Days If LESS than 1 day,	and that death occurred, on the date stated above, at		
B 2 4 4 5	O O O O O O O O O O O O O O O O O O O	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT		
E tell A	8. OCCUPATION OF DECEASED	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH* was as follows:		
NE SEE	(a) Trade, profession, or			
IN RESERV THIS IS A carefully suj	particular kind of work	Bullism		
A I I I I	(b) General nature of industry, business, or establishment in	<u>u-</u>		
RGI RGI RGI CUF	which employed (or employer)			
. <i>つって</i> きむ	(c) Name of employer			
	9. BIRTHPLACE (city or town) Won , 2000	(duration)yrs,mos,ds.		
show OF I	(State or country)	CONTRIBUTORY		
	10. NAME OF FATHER	(Secondary) (duration)yrsds.		
runklen CAUSE statemen	J. J.	ll		
UNI CAU	11. BIRTHPLACE OF FATHER (city or town)	if not at place of death?		
, m.v.	11. BIRTHPLACE OF FATHER (cittor town) (State or Country)  12. MAIDEN NAME OF MOTHER (CITTOR TOWN)	Did an operation precede death? Date of		
WITTH of info I state Exact	12. MAIDEN NAME OF MOTHER PORMUSE	Was there an autopsy?		
, a ii	Gorde 11 coons	What test confirmed diagnosis		
NLY, iftem c	18. BIETHPLACE OF MOTHER (city or town) (State or County)	(Signed) Dru. Haanderson. M. D.		
· = -	(State or county) Jacque	200 Mary 1930 - (Address) Right & dalo.		
E PLA-Every	14. South & Spinner	19. Place of Burial Cremation, or Removal Date of Burial		
	Informant (Address) State And Both	Basalt Idalo pol po 103		
WRITTE N. B.—I.	15. V Decet &	20. Undertaker Address		
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STATE OF IDAHO FORM V. S. No. 20 Mc 1-19. IQRERTIFICATE OF DEATH T RECORD

XACTLY, PHYSICIANS should

statement of OCCUPATION is DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS Registration District No..... County of State File No..... Primary Registration District No. 20/5 Local Registrar's No.... City of.... If death occurred in a hos-If death occurs away from pital, institution or camp, usual residence, give facts give its NAME instead of called for under special instreet and number. formation. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 4. COLOR OR BACE 5. SINGLE, MARRIED, WID-OWED OB DIVORCED 16. DATE OF DEATH (Year) (Day) (Month). 6. DATE OF BURTH I HEREBY CERTIFY, That I attended deceased from 17. (Month) (Day) (Year) IF LESS than 1 7. AGE day how many The CAUSE OF DEATH\* was as follows: 8. OCCUPATION (a) Trade, profession or particular kind of work..... (b) General nature of in-(Duration) yrs. mos. ds. dustry, business or establishment in which employ-Contributory ed (or employer)..... (Secondary) 9. BIRTHPLACE (State or Country) 10. NAME OF Father (Address) \*State the Disease Causing Death; or in deaths from Violent 11. BIRTHPLACE Causes, state (1) Means of Injury, and (2) whether Accidental, OF FATHER (State or Country) Suicidal or Homicidal. 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, 19. MAIDEN NAME Transients or Recent Residents.) OF MOTHER In the At place 18. BIRTHPLACE of death.....yrs.....mos......days. State.....yrs.....mos......ds. OF MOTHER Where was disease contracted (State or Country if not at place of death?.... 14. THE ABOVE IS Former or usual residence ..... (Informant) 19. PLACE OF BURIAL OR REMOVAL 15. 20. UNDERTAKER Local Registrar

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PLACESTER FFR 5 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No. State File No. (If born in hospital or institution Prim. Registration District No. 1.00 give name.) FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of child) Number Twin Date of Legiti-Sex of Triplet in order birth Child or other? of birth mate? Month) (To be answered only in event of plural births) Number of child of this mother, including present birth. (a) Born alive and new living Born alive but now dead... Stillborn. MOTHER FULL MAIDEN each. Residence (Usual place of abode) Residence (Usual place of abode) If nonresident, give place and State If nonresident, give place and State Color or race Age at last Birthday... 9 (Years) (Years) Birthplace Birthplace -(City and State or County) and State of Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE® I hereby certify that I attended the birth of this child, who was \ Stillborn on the date above stated. 6 (Signature) case \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

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•	RECL. LD FEB 5 1080	DEPARTMENT OF PUBL		DO NOT WRITE IN THIS	3 SPACE
PHYSICIAN	PLACE OF DEATH	BUREAU OF VITAL S'		State File No.	8993
: <b>2</b>	County of Ada.	CERTIFICATE OF			
. <b>8</b>	City of Boise. Reg	sistration District No.		<b>j</b> .	21
		mary Registration District		Local Registr	ar's No.
		St. Lukes "	ognital.	/	
<b>×</b>	(No	in a hospital or institution, give	M.M.W.M.M.Sdm.R	of street and number.)	. (_
ied T					, ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~
ssift b b	2. FULL NAME Baby	soyenger.	······································		
	(a) Residence. No.		St	(If nonresident give city or	town and State.)
ted trions	(Usual place of abode.)  Length of residence in city or town where death	occured. yrs. mo3.	ds. How long	in U. S. if of foreign birth?	vrs. mos. ds.
sta sta prope	PERSONAL AND STATISTICAL P		*	MEDICAL CERTIFICATE OF DE.	ATH
ii e s ii	3. SEX 4. COLOR OR RACE 5.	Single, Married, Widowed, Divorced (write the word.)	16. DATE OF		•
. " Says	Male. White.	Single.	i	January 14th 1930	) 19 (Year)
BINDING ENT REC GE shoul at it may	5a. If married, widowed, or divorced				
E t s t	HUSBAND of		17. I HEREB	Y CERTIFY, That I attended deceas	d from
Ta High	(or) WIFE of			, 19, to	
- 4240	6. DATE OF BIRTH (month, day and year)	anuary 14th 1930	11	h alive on	
FOR RMA	7. AGE Years Months Days	If LESS than 1 day,	ll .	/	ove, atm.
_ 🖼 🀱 🛧 🖎		hrs. or		# L # D ~ 1"	
VE PP	0 0 0	- mu	CAUSES, stat	e (1) MEAN AND NATURE C	INJURY, and (2)
	8. OCCUPATION OF DECEASED (a) Trade, profession, or		The CAUSE O	ISEASE CAUSIN DEATH OF IN C e (1) MEAN AND NATURE O DENTAL, SUSUIDAL, or HOMICIO F DEATH* was as follow:	ア・ル
RESERVED IS IS A P. fully suppli plain term	particular kind of work 1000.				, , ,
E 9 a 5	(b) General nature of industry,		1		.5
INK—TI I be car	business, or establishment in which employed (or employer)				~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
	(c) Name of employer				<del>Y</del>
MAR INK INK Be be OCCU	Dod o	T 3 a 3 a			ds
	9. BIRTHPLACE (city or town) Bouse	4TURUO.			,
日共富			CONTRIBUTO (Secondary)		
UNFADI	10. NAME OF FATHER			(duration)yrs.	ds
WITH UNFA of information state CAUSE Exact stateme	G. L. Bo	Aeuger.	18. Where wa	as disease contracted	
	11. BIRTHPLACE OF FATHER (city or tow	(n)	if not at	place of death?	
et fig 3	(State or Country) Folland.	Mich.	li	ion precede death? Date	of
WIII of inf state Exact	11. BIRTHPLACE OF FATHER (city or tow (State or Country) Folland.  12. MAIDEN NAME OF MOTHER Peters	220	ll .	autopsy?	
	troleuge reg		11	nfirmed diagnosis?	200
be Et	13. BIRTHPLACE OF MOTHER (city or to (State or County)	wn)	(Signed)		7.3-1-
	(State or County) Ill.		1/14/30		, Laano.
FPLA	G. L. Bowenge:	r.	19. Place of	Burial, Cremation, or Removal	Date of Burial
色胃	Informant G. J. Boyenge:  (Address) Boise.Id	aho.	Morris	Fill Cemetery. 1	/14/30 19
write 7. b.—1	3	1/K/Pl			Se Ida.
₿ż	15. Filed / -/ C/ 19.30 (	N/I.VMoals	1		o , Tua .

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STATE OF IDAHO County of DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS City of. CERTIFICATE OF BIRTH No. Registration District No.....State File No..... If born in hospital or institution, Prim. Registration District No. 1004 Logo Registrar's No. 5 give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Sex of Number Triplet Legiti/ Date of in order Child or other? mate birth (To be rasw red only in event of plural births) (Month) What prophylactic was used to prevent Ophthalmia Neonatorim? Born alive but now dead..... Stillborn ..... FULL MAIDEN NAME NAME .... Residence (Usual place of abode).... It non-resident, give place and State. If non-resident, give place and State Color or race. Birthplace ..... Birthplace ... (City and State or County) Occupation Laterca Occupation ..... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. PLAINLY I hereby certify that I attended the birth of this child, who was & Stillborn on the date above stated. (Signature) \*Where there was no attending physician WRITE or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth.

Meglat State A CONTRACTOR Teday (I protor fired to Cred her same west only in comment of Chings The was used so proved to the party with the tunner aufhafont and tour and the present of the present of The truth of the truth of the state of the s THE PARTY. Age of hat Birthday garden mel la sa come STATE LITTING (11) and some or County) and or no .... Occupation Mar with Ha Ne Colbatha say And Live All Sales was die and the second to the THE PARTY OF attending nhymoder A STATE WANTEN the milderer, then the conference made should nake this ager total

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N N	STATE OF IDA	HO
<b>3</b> €	RECEIVED FEB 5 1080 EPARTMENT OF PUBLI	C WELFARE DO NOT WRITE IN THIS SPACE
rsici/	PLACE OF DEATH BUREAU OF VITAL ST	TATISTICS  State File No. 68999
<u>8</u> 00	CERTIFICATE OF	DEATH State File No
2 HA	County of Registration District No	2 / /
7 P.	City of Journal	Local Registrar's No.
28 LX, men	Primary Registration District	No. 7
	(No. A Juliu	s Joshile D
778 ORD ACTLY, statemen	(If death occurred in a hospital or institution, give its	name instead of street and number.)
	2. FULL NAME Infant Multan	,
		Q41 54 30 6
75.73	(a) Residence. No	(If nonresident give city or town and State)
sta d.	Length of residence in city or town where death occurred. yrs. mos. ds.	How long in U. S., if of foreign birth? yrs. mos. ds.
2 .= :	PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
GERMA) uld be classifi	8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed,	16. DATE OF DEATH
ING PER] should	or Dispreed (write the word)	Jun 14 1030
Z 4 2	The Trace Peng q	(Month) (Day) (Year)
<b>□ &lt;</b>	5a. If married, widowed, or divorced HUSBAND of	17. I, HEREBY CERTIFY, That I attended deceased from
IS IS IS IS IS IS IS	(or) WIFE of	Jun 14 1930 to 10
	6. DATE OF BIRTH (month, day and year) Lanuary 14-1930	that I last saw h alive on 19
FOR THIS ed.	7. AGE Years Months Days If LESS than 1 day,	
7 1 12 2 2	hrs, or	and that death occurred, on the date stated above, at
EVED FOUND TO Supplied it may tifficate.	min.	The CAUSE OF DEATH* was as follows:
RVE INK sup it	8. OCCUPATION OF DECEASED	
SE PA	(a) Trade, profession, or particular kind of work	Jan John.
N RESERVEI TADING INK- carefully supp 8, so that it m		
_ ~ # ~ ~	(b) General nature of industry, business, or establishment in	(duration) yrsmosds.
RGIN UNE, be ca erms,	which employed (or employer)	CONTRIBUTORY
RGIN UNF be c erms	(c) Name of employer	(Secondary)
A H H H H		(duration)yrsmosds.
MANTTH Should plain ction	9. BIRTHPLACE (city or town)	18. Where was disease contracted if not at place of death?
, V	10. NAME OF FATHER W	Did an operation precede death? Date of
(LY tion 'H' i	Cohest A Marillar	1)
Z	11. BIRTHPLACE OF FATHER (city on town)	Was there an autopsy?
PLAI Iform DEA' See		What test confirmed diagnosis?
	i cury grea	(Signed) M, D.
WRITE item of	(State of Country)  (State of Country)  (Alefornia  12. MAIDEN NAME OF MOTHER)	(Address)
WRITE m of i ISE OF	assig energy	<b>/</b>
WRI item o AUSE importa	18. BIRTHPLACE OF MOTHER (city or town)	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
7.5	10 - 7041	whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
very ate C	14. Mrs. T/3 Deviles	19. Place of Burial, Cremation, or Removal Date of Burial
	Informant J. C.	Mark's 4/1000 + 1/ 1976
1 28 :81	(Address) 2 // Masontay (1)	resource Hay unuly Jun 16 30
	15. Filed / - 15 1930 W. Whodes	0. Undertaker Address
- 45	Registrar	Juniners & /refs. Doise Idahu.
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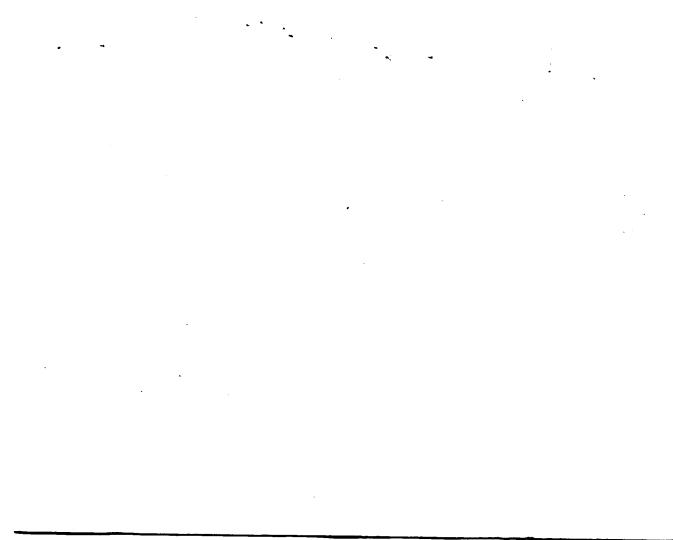
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Do not accept a certificate of death signed only by a

midwife.

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STATE OF IDAHO ed EXACTLY, PHYSICIANS
Exact statement of OCCUPA 1680 DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VYTAL STATISTICS CERTIFICATE OF DEATH State File No..... County of Registration District No..... Local Registrar's No..... Primary Registration District No. 202 EXACTLY, A PERMANENT RECORD 2. FULL NAME (a) Residence. No......St. (Usual place of abode) (If nonresident give city or town and State) Length of residence in city or town where death occurred. ds. How long in U. S., if of foreign birth? yrs. mos. yrs. mos. properly classified. PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH SEX 4. COLOR OR RACE 5. Single, Married, Widowed. 16. DATE OF DEATH should or Divorced (write the word) BINDING (Month) If married, widowed, or divorced AGE HUSBAND of 17. I HEREBY CERTIFY, That I attended deceased from S (or) WIFE of THIS 6. DATE OF BIRTH (month, day and year) that I last saw h\_\_\_\_ alive on\_\_\_\_\_\_\_\_19 7. AGE Months If LESS than 1 day, that it may certificate. Days supplied and that death occurred, on the date stated above, at \_\_\_\_\_\_\_m .....hrs. or UNFADING INK-The CAUSE OF DEATH\* was as follows: 8. OCCUPATION OF DECEASED that carefully (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in (duration) which employed (or employer) .... CONTRIBUTORY & out (c) Name of employer (Secondary) lain .......yrs, \_\_\_\_mos. 9. BIRTHPLACE (city or town 18. Where was disease contracted (State or country) if not at place of death? \_\_ 0. NAME OF FATHER Did an operation precede death? Date of CAUSE OF DEATH in r important. See instr Was there an autopsy? ..... 11. BIRTHPLACE OF FATHER (city or town) PARENTS What test confirmed diagnosis? (State or Country) (Stigned) .... 18. BIRTHPLACE OF MOTHER \*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (State or Country 14. 19. Place of Burial, Cremation, or Removal Date of Burial Informant. 19 (Address) 20. Undertaker Address

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Do not accept a certificate of death signed only by a

## RECEIVED MAR 7 1930

DIVISIÓN OF VITAL STATISTICS

DEPARTMENT OF COLMERCE BUREAU OF VITAL STATISTICS

C.K. MACEY SPECIAL AGENT

Boise, Idaho

MAR 3 1930

Mrs. W.B. Richard BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT. Carey DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

EVILL MANUE OF OUTTO

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenhence. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

DATE OF BIRCH	Jan. 17,	1930	SEX OF	Female
to this mother, ow living	including p	present	birth2	5
born			3	
(Please write p	lainly)			
-	Int			ference
Richards	Verme	le fo	uise St	anfor
<i>o</i>				
37	Age at las	st birth	iday 3	<del>/</del>
	Salts	Cake T	bity thplace)	ltah
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	BIRCH to this mother, by living	to this mother, including pow living  [Dorn (Please write plainly)  ace to Institute of the Care  37 Age at last salt seems of the Salt se	to this mother, including present ow living  [Dorn (Please write plainly)  ace to Information M. G.  Richards Vermile for (Res. 37)  Age at last birth  Salt Lake 1  (Bir	to this mother, including present birth  by living  CHILD  to this mother, including present birth  Diving  CHILD  CHILD

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C.K. Macey

Special Agent, Bureau of the Census.

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RECORD EXACTLY, PHYSICIANS tact statement of OCCUPA-	PLACE OF DEATH  County of Sannerelle City of Salar Salar  (If death occurred in a hospital or institution, give its  2. FULL NAME  STATE OF IDA  DEPARTMENT OF PUBLIC  BUREAU OF VITAL ST  CERTIFICATE OF  Registration District No  (No	DO NOT WRITE IN THIS SPACE State File No	
" ~ X	(a) Residence. No	St.  (If nonresident give city or town and State)  How long in U. S., if of foreign birth? yrs. mos. ds.	
MAN. be i	PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH	
	8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)  White New Boam	16. DATE OF DEATH 193	
A la sa	5a. If married, widowed, or divorced HUSBAND of (or) WIFE of	(Month) (Day) (Year) 7  17. I HEREBY CERTIFY, That I attended deceased from	
SERVED FOR BINJ G INK—THIS IS J Iy supplied. AGE nat it may be prope certificate.	6. DATE OF BIRTH (month, day and year) /-/5-30	that I last saw h. alive on , 19	
	7. AGE Years Months Days If LESS than 1 day,	and that death occurred, on the date stated above, at	
	min.	The CAUSE OF BEATH was as follows:	
	8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work	4th mo, gestation	
RES DING efull so th	(b) General nature of industry.	and hearic Illness	
NFA NFA NFA Back	business, or establishment in which employed (or employer)  (c) Name of employer	CONTRIBUTORY (Secondary)	
Z # # 5 0	PROS 9/11.7.1	(Secondary) (duration)yrs,mosds.	
MAWITH Should plain ction	9. BIRTHPLACE (city or town) S. 13 State (State or country) Jasha Falfo. Jaalio.	18. Where was disease contracted if not at place of death?	
M VLY, WITH tion shoul I'H in plain instruction	10. NAME OF FATHER  May Freeman Name	Did an operation precede death? Date of Was there an autoport	
PLAINLY nformation DEATH	11. BIRTHPLACE OF FATHER (city or town) Apple (State or Country)  Line 12. MAIDEN NAME OF MOTHER	What test confirmed markets C. Release, M. D.	
TE of ir OF	12. MAIDEN NAME OF MOTHER  Madel Lenger	19(Address)	
WRITE 1 y item of in CAUSE OF y important.	13. BIRTHPLACE OF MOTHER (city or town) Skower  (State or Country) Wyamuug	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
Every state C is very	14. Informant Tayyun & Hagusy	19. Place of Burial, Cremation, or Removal Date of Burial	
is is	(Address) MAMO Falls AANO	20. Undertaker Address	
N. B. should FION	15. Filed less 14-, 193 D Misses Registrar	-	
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STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
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Do not accept a certificate of death signed only by a

STATE OF IDAHO 1930 PEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH No. Registration District No... State File No..... TE RETURN (If born in hospital or institution Prim. Registration District No.21 Local Registrar's No...3 give naz.) FULL NAME OF (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Sex of Legiti-Date of Triplet in order and Child / or other? birth ... mate?WS (To be answered only in event of plural births) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth.............. (a) Born alive and now living.... Born alive but now dead....... Stillborn FATHER FULL MAIDEN Residence (Usual place of abode) It non-resident, give place and State If non-resident, give place and State... Color or race INTUIL Birthplace ..... Birthplace .. (Zity and State or/County) (City and State on County) Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. PLAINLY Case of mo I hereby certify that I attended the birth of this child, who was | Stillborn on the date above stated. \*Where there was no attending physician WRITE or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

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(6	cliysician or midwife	dresn	physitian puscholder, i A stillborn bathes nor   Ad	re was no altermine then the father, he diske this return, a that helder one conflicted on life a	Alembio 20 Leade July for Joe de Albfa

A-A-	RECEIVED FEB 1 7 1930 STATE OF IDAI	HO		
AK.	DEPARTMENT OF PUBLIC			
) ) ) )	CEDTIFICATE OF	4. 13 72 (11 ) 1		
PHYSICI	County of Samuel Registration District No	73		
i i	City of Registration District	Local Registrar's No.		
TLY eme		<b>A</b>		
A C. Tat	(No	name instead of street and number.)		
RECORD EXACTLY, I	2. FULL NAME / Say Octors Still turn)			
_ <del></del>	(a) Residence. No. A. Maspiter	St. (If nonresident give city or town and State)		
ENT ] stated d. Ex	(Usual place of abode)  Length of residence in city or town where death occurred.  yys. mos. ds.	How long in U. S., if of foreign birth? yrs. mos. ds.		
G ERMANEN puld be sta classified.	PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH		
ZM. d b assi	8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)	16. DATE OF DEATH		
	m white -	(Month) (Day) (Year)		
T & E	5a. If married, widowed, or divorced HUSBAND of	17. I HEREBY CERTIFY, That I attended deceased from		
FOR BINDING THIS IS A PE ied. AGE shou by be properly of	(or) WIFE of	, 19, to, 19		
	6. DATE OF BIRTH (month, day and year) Yau - 30 - 30	that I last saw h alive on, 19		
	7. AGE Years Months Days If LESS than 1 day,hrs. or	and that death occurred, on the date stated above, atm.		
EVED FOUNKTHE Supplied. it may lift the tificate.	ence one	The CAUSE OF DEATH* was as follows:		
₩ _ ++ £	8. OCCUPATION OF DECEASED	3 till harry		
RESE DING refully so tha	(a) Trade, profession, or particular kind of work			
<b>€</b> # #	(b) General nature of industry, business, or establishment in	ds		
RGIN UNE be ca erms,	which employed (or employer)	CONTRIBUTORY		
<b>⋞</b> * ≎	(c) Name of employer	(Secondary) (duration) yrs, mos, ds.		
MAWITH Should plain ction of	9. BIRTHPLACE (city or town)	18. Where was disease contracted		
. ~ e P	10. NAME OF FATHER	if not at place of death?		
PLAINLY, information DEATH is See instr	Devey eterson	Was there an autopsy?		
PLAINLY nformation DEATH See inst	11. BIRTHPLACE OF FATTIER (city or town) (State or Country)	What test confirmed disgnals?		
PL Die	(State or Country)  12. MAIDEN NAME OF MOTHER	(Signed) M. D.		
	12. MAIDEN NAME OF MOTHER	Jan. 30, 1930 (Address) de la falla Ma.		
WRITE m of i ISE OF	18. BIRTHPLACE OF MOTHER (city or town) The State	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT		
iter AU;	(State or Country)	CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
W—Every iter I state CAU; is very imp	14. 00' P (1 Person)	19. Place of Burial, Cremation, or Removal Date of Burial		
Eve	Informant (Address)	100 100 100 100 100 100 100 100 100 100		
Paris N		20. Underlaker Address		
N. B should TION	15. Filed 3 D (, 1913 D CACCONTRICTER)	" Claur -		
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DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

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mawne.

RECORD be made for STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH PERMANENT RETURN must Registration District No. State File No. (If born in hospital or institution 5 Local Registrar's No. Prim. Registration District No. give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Date of Sex of Legiti-Triplet in order birth Childor other? (To be answered only in event of plural births) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth. (a) Born alive and now living Born alive but now dead. Stillborn FULL FULL MAIDEN Residence (Usual place of abode) child If nonresident, give place and State If nonresident, give place and State one Birthplace City and State or Country) (City and State or Coudtry) Occupation Occupation and I hereby certify that I attended the birth of this child, who was i PLAINLY on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, Physician or midwife WRITE etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

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t, PHYSICIANS ent of OCCUPA-	PLACE OF DEATH  County of City of Called Burel District No	DO NOT WRITE IN THIS SPACE State File No. 69129
BINDING IS A PERMANENT RECORD AGE should be stated EXACTLY, properly classified. Exact statemen		St.  (If nonresident give city or town and State)
UNFADING INK—THIS be carefully supplied. Lerms, so that it may be no back of certificate.	6. DATE OF BIRTH (month, day and year) 1-20-30  7. AGE Years Months Days If LESS than 1 day, hrs. or Stillborn. min.  8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer	and that death occurred, on the date stated above, at m.  The CAUSE OF DEATH* was as follows;  Which was a follows;  (duration) yrs. mos. ds.  CONTRIBUTORY (Secondary)  (duration) yrs. mos. ds.
WARITE PLAINLY, WITH item of information should AUSE OF DEATH in plain important. See instruction of	9. BIRTHPLACE (city or town) Caldwell, Ldaho (State or country)  10. NAME OF FATHER Orval Jordan  11. BIRTHPLACE OF FATHER (city or town) (State or Country)  Kansas  12. MAIDEN NAME OF MOTHER Ethel Wilson  18. BIRTHPLACE OF MOTHER (city or town) (State or Country)	18. Where was disease contracted if not at place of death?  Did an operation precede death?  Was there an autopsy?  What test confirmed diagnosis?  (Signed)  (Signed)  (Address)  State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
N. B.—Every should state C.	14. Informant Orval Jordan (Address) Caldwell Ida  15. Filed /-20-, 1934. John S. Meyes. Registrar	19. Place of Burial, Cremation, or Removal Canyon Hill Jan 20 1930  20. Undertaker Paul L. Case Caldwell Idaho

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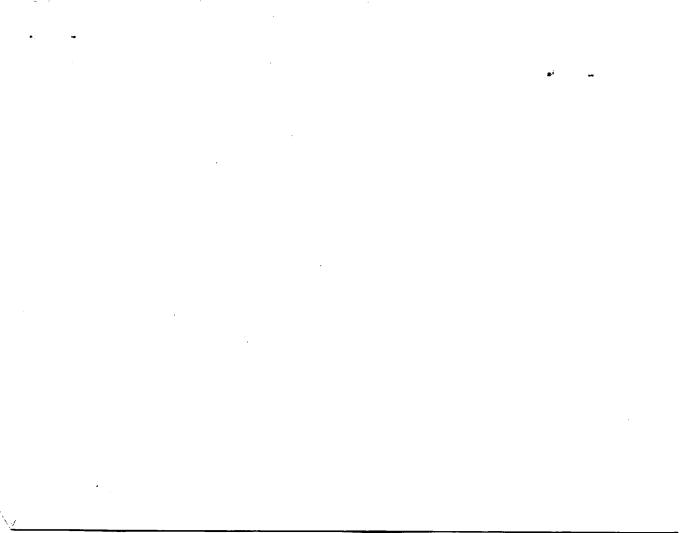
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Do not accept a certificate of death signed only by a midwife.

RECORD be made for STATE OF IDAHO 1930 DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS City of CERTIFICATE OF BIRTH PERMANENT | RETURN must h th stated. Registration District No... State File No..... Frim Begistration District No. 200 (If born in hospital or institution Local Registrar's No. /6 give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Number / in order Date of Sex of Legitibirth mate? Child (To be answered only in event of plural births) Month) What prophylactic was used to prevent Ophthalmia Neonatorum 7/ Number of child of this mother, including present birth. (a) Born alive and now living... Born alive but now dead. Stillborn FATHER FULL MAIDEN NAME \_\_ MOTHER Residence (Usual place of abode) Residence (Usual place of abode). If nonresident, give place and State If nonresident, give place and State Birthplace Birthplace (City and State or Country) (City and State or Country) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* Portradition) I hereby certify that I attended the birth of this child, who was L. Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

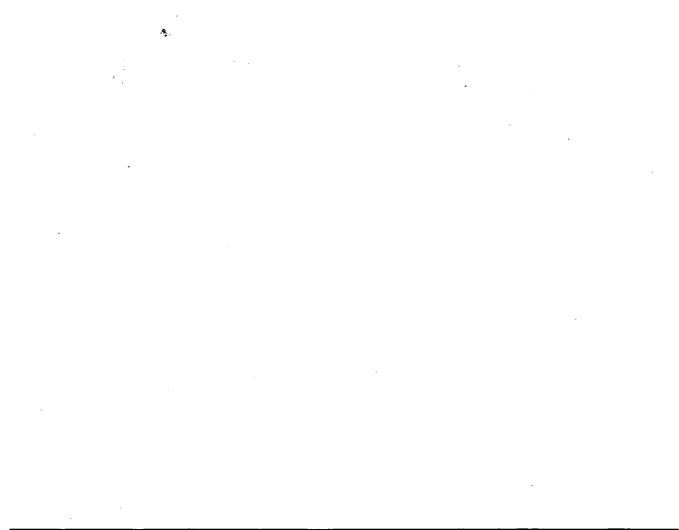


STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: Farmer (retired. 6 yrs.). For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs. meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of use of "Tumor" for malignant neoplasms): Measles: Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere exopheumonia (secondary), 10 as. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUER-PERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train -accident; Revolver wound of head-homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory."

PERMANENT RECORD TE RETURN must be made birth stated.	County of FEB 10 1000 City of Cliffon Isa	COMPANY OF THE OF THE OF
T R mus	No	District No. 22 State File No.
ANEN FURN stated	(If born in hospital or institution give name.)	ration District No2///Local Registrar's No
ERM RET	FULL NAME OF CHILD Stilltorn (If stillborn	n, substitute the word "Stillbirth" for name of child)
RA7	Sex of Child Male Twin Triplet and Number in order or other? To be answered only in event of plural	births)  Legiti- mate?  Date of Joint 19-3  (Month) (Day) (Year)
EPA ord	What prophylactic was used to prevent Ophthalr	nia Neonatorum?
	Number of child of this mother, including present be	irth
INK—birth	Born alive but now dead	Stillborn
E C E	FULL Storge Merrill Capiner	FULL MOTHER MAIDEN Welda Kofrel
per liber	Residence (Usual place of abode) Sufflow I da	Residence (Usual place of abode) Clifton Sa
FADIN child numbe	It non-resident, give place and State	If non-resident, give place and State
the the	Color or race. W. Intly Age at last Birthday	Birthplace Cutton San (Years)
WITH e than	Occupation State of County) O. S.	(City and State or County)
ラ 長 舟 川	CERTIFICATE OF ATTEN	DING PHYSICIAN OR MIDWIFE
PLAINLY case of mo for eac	I hereby certify that I attended the birth of t on the date above stated.	his child, who was Stillborn at 1930 M
WRITE F	*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.	Address Filed 20 1930
1		Registrar.



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PLACE OF MRTH
         DEPARTMENT OF PHACIC WELFARE
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               ("EHTHFICATE OF ATTENDING PHYSICIAN OR MIDWIFE"
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                  I hereby scutity that I attended the birth of this child, who was Estillation
                                                    on the date above stated.
               (Signature) Land
                                        States there was no attending physician :
      (Physician de midwife)
                                         or midwife, then the father, householder,
                                         etc., should make this return. A stillborn
                                         child is one that neither broathes nor
                                         shows other evidence of life after birth.
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4. DATE OF BIRTH  4. DATE OF BIRTH  (Month) (Day) (Year)  (Month) (Day) (Year)  7. AGE  IF LESS than 1 day how many hrs. or hrs. or hrs. or particular kind of work.  (B) General nature of industry, business or establishment in which employ-	FARE
PERSONAL AND STATISTICAL PARTICULARS  8. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID- OWED OR DIVORCED  Wile the word)  6. DATE OF BIRTH  7. AGE  IF LESS than 1 day how many hrs. or particular kind of work.  8. OCCUPATION (a) Trade, profession or particular kind of work.  (b) General nature of in-	_
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Mal white (he word)  6. DATE OF BIRTH  (Write the word)  6. DATE OF BIRTH  (Month) (Day) (Year)  (Month) (Day) (Year)  That I hereby Certify, That I attended deceased that I last saw have alive from the date stated above, at 1970.  The CAUSE OF DEATH* was as follows: Prolapse particular kind of work  (a) Trade, profession or particular kind of work  (b) General nature of in-	
Mal white (he word)  6. DATE OF BIRTH  (Write the word)  6. DATE OF BIRTH  (Month) (Day) (Year)  (Month) (Day) (Year)  That I hereby Certify, That I attended deceased that I last saw have alive from the date stated above, at 1970.  The CAUSE OF DEATH* was as follows: Prolapse particular kind of work  (a) Trade, profession or particular kind of work  (b) General nature of in-	
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The CAUSE OF DEATH* was as follows: Brolapse    Social Continuous	U.
Yrs Mos ds min.?  S. OCCUPATION  (a) Trade, profession or particular kind of work  (b) General nature of in-	4
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Father Harris a Stephenson 18. 19.20. (Address) Preston Ida	
Father  18. 19.20. (Address) State University of the Country of th	
Causes state (1) Means of Injury; and (2) whether Accide	dental,
Suicidal or Homicidal.	
2 4 1 DESTRENCE (Por Hospitals Institut	utions,
At place In the of deathyrs	ds.
(State or Country) (Make the was disease contracted if not at place of death?	
Informant) Acres a. Stephenson usual residence	
(Informant)   Corres a. Stephenson   Former or usual residence   19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL DA	
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Local Registrar M. W. Sendreck Prestox	

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer. Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager." "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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RECORD be made for	City of Siles  No. St.	STATE OF IDAHO RIMENT OF PUBLIC WELFARE REAU OF VITAL STATISTICS CERTIFICATE OF BIRTH  S 178260
PERMANENT   RETURN must h th stated.	Turin ) (Number	n District No
IS A ATE f bir	Sex of Child Triplet and in order or other? and or other?	
THIS SEPA n order	Number of child of this mother, including present birth  Born alive but now dead.	(a) Born alive and now living O
Sta	FULL NAME Conard Veddet  Residence (Usual place of abode) Liebs, Ida	FULL MAIDEN Loth Catter—  Residence (Usual place of abode) Cafe, 21
UNFADING one child at bit in number of each	If nonresident, give place and State  Color or race white Age at last Birthday 28 (Years)	If nonresident, give place and State  Color or race Age/at last Birthday (Years)
TTTH than d the	Birthplace City and State or Country)  Occupation CERTIFICATE OF ATTENDING	Occupation January
of more	I hereby certify that I attended the birth of this chil on the date above stated.  (Signa	id, who was Schlborn at
69260 WRITE PLA N. B.—In case	*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.  Address Filed	1/ 1/

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<u>(2)</u>	STATE OF IDA	но
AP.	RECEILED FEB 15 1930 DEPARTMENT OF PUBLIC	C WELFARE DO NOT WRITE IN THIS SPACE
<u> </u>	PLACE OF DEATH BUREAU OF VITAL ST	ATISTICS CORRE
	County of Roolemain CERTHICATE OF	DEATH State File No
E S	Registration District No	36
C #	City of Primary Registration District	No. 1.6.5.0 Local Registrar's No. 2.1
E LY		
E C E	(No	7 1 1601
RECORD EXACTLY, PHYSICIAN cact statement of OCCUPA	2. FULL NAME Leon a Bell Ved	lder.
Feet 175	(a) Residence. No.	st Gebbs. Idia.
ENT stated d. Es	(Usual place of abode)  Length of residence in city or town where death occurred. yrs. mos. ds.	(If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.
PERMANENT hould be stated y classified. E	Actigor de l'obseque in des de soute made desse soute	
TING PERMANE should be st rly classified	PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
R.W. Idasi	3. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)	16. DATE OF DEATH
PE	h Wi single	(Month) (Day) (Year)
	5a. If married, widowed, or divorced HUSBAND of	17. I HEREBY CERTIFY, That I attended deceased from
AGE prope	(or) WIFE of	, 19, to, 19
	6. DATE OF BIRTH (month, day and year) 1930 - 1-10.	that I last saw h alive on 19
rOK THIS ed	7. AGE Years Months Days If LESS than 1 day,	and that death occurred, on the date stated above, at 11 6 mm.
ata blic	O O min,	The CAUSE OF DEATH* was as follows:
KVED INK— supplications tifficate	8. OCCUPATION OF DECEASED	
eat a rest	(a) Trade, profession, or particular kind of work	Caphyxia Constarum
	1	delte prolonged deficult
A KES FADIN carefull s, so th	(b) General nature of industry, business, or establishment in	(duration) yrs. mos. ds.
전 C - ' 글 및 '	which employed (or employer)	CONTRIBUTORY
€ ~ 0	(c) Name of employer	(Secondary)
WITH WITH should plain ction	9. BIRTHPLACE (city or town) Coeura dene	(duration)yrsmosds.  18. Where was disease contracted
Sh Sh	(State or country)	if not at place of death?
stri st	10. NAME OF FATHER	Did an operation precede death? No Date of
PLAINLY information DEATH i	11. BIRTHPLACE OF PATHER (city/or town)	Was there an autopsy?
PLAI form DEA' See	11. State or Country   11. MAIDEN NAME OF MOTHER   12. MAIDEN NAME OF MOTHER   12. Volter	What test confirmed diagnosis?
		(Signed) M. D.
WRITE m of i	12. MAIDEN NAME OF MOTHER Sells Poller	(Address) Coccos
/RI SE	18. BIRTHPLACE OF MOTHER (city or town)	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
14 T E	(State or Country)	CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL
	14. 1. March 1 15 1/2:	019. Place of Burial, Cremation, or Removal Date of Burial
Every state ( is very	Informants Little Usa (16	Corest Com 25 Jun 1-12 1985
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DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

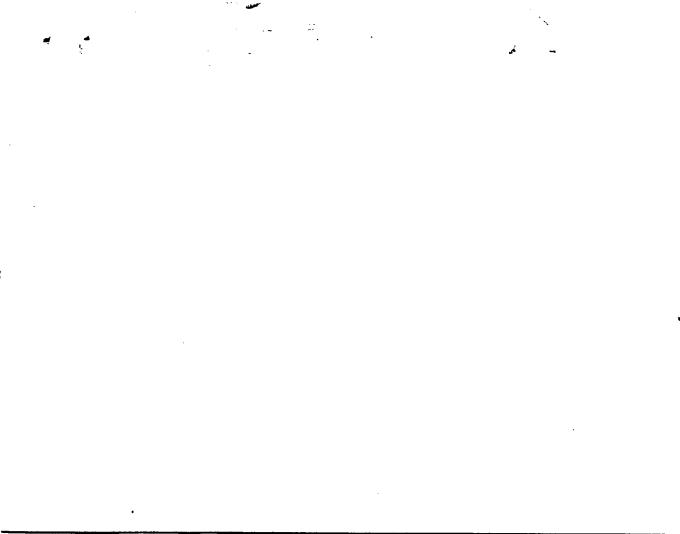
Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.



CIANS CUPA-	RECEIVED FEB 12 19	STATE OF IDAI DEPARTMENT OF PUBLIC BUREAU OF VITAL ST	C WELFARE DO NOT WRITE IN THIS SPACE
PHYSICE t of OCCU	Talal	CERTIFICATE OF	- EU968 - E
F. F.	County of County	Registration District No	66
	City of Oou	Primary Registration District	I and Danishuaut, 37
r RECORD ed EXACTLY, Exact statement	2. FULL NAME (a) Residence. No.	(No. ped in a poital or institution give its	name instead of street and number.)
a Z	(Usual place of abode) Length of residence in city or town where d	eath occurred. yrs. mos. ds.	(If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.
ANI ifie	PERSONAL AND STATISTI	CAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
DING A PERMANENT should be state erly classified. E	temals Huis	5. Single, Married, Widowed, or Divorced (write the word)	16. DATE OF DEATH /2 1930
BINDING IS A PERMANE AGE should be st properly classified.	5a. If married, widowed, or divorced HUSBAND of (or) WIFE of	-4	17. I HEREBY CERTIFY, That I attended deceased from
	6. DATE OF BIRTH (month, day and year	Jan 12/1930	that I last saw h alive on 19
ID FOR X—THIS oplied. may be cate.	7. AGE Years Months	Days If LESS than 1 day,	and that death occurred, on the date stated above, at
GERVED FCG INK—TE by Supplied.		min.	The CAUSE OF DEATH* was as follows:
	8. OCCUPATION OF DECEASED		J. J
RESER DING I efully so that of cert	(a) Trade, profession, or particular kind of work		SW JSV TV
	(b) General nature of industry, business, or establishment in which employed (or employer)		(duration) yrs. mos. ds.
ARGIN UNF/ be ca terms, on bacl	(c) Name of employer		CONTRIBUTORY (Secondary)
MA WITH should plain ction o	9. BIRTHPLACE (city or town)		(duration)yrsmosds,
	(State or country)	11.11	18. Where was disease contracted if not at place of death?
NLY, stion griff in instru	10. NAME OF FATHER	tell	Did an operation precede death? Date of
PLAINLY nformation DEATH i	11. BIRTHPLACE OF FATTER (city of (State or Country)	fown)	Was there an autopsy?  What test confirmed diagnosis?
<b>=</b> .	11. BIRTHPLACE OF FATTER (city of (State or Country)  12. MAIDEN NAME OF MOTHER	We head	(Signed) M. D. M. D. Address Paloring Mr. D.
iff.	13. BIRTHPLACE OF MOTHER (city (State or Country)	or town Millauni	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
Every state C is very	14. Informant (Address)	Wash	19. Place of Buriel, Cremation, or Removal Pate of Burial
N. B.—] should s rion is	15. Filed Pour 4, 1931.	for Thomper	Tondertaker Address Wall
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STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE RECORD County BUREAU OF VITAL STATISTICS City CERTIFICATE OF BIRTH Registration District No.... State File No..... PERMANENT E RETURN Dirth stated. (If born in hospital or institution give name.) Prim. Registration District No. 1019 Local Registrar's No. FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Number SEPARATE In order of b Twin Date of Legitiin order Sex of -Triplet birth mate? or other? Child (To be answered only in event of plural births) (Month) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth. 5 (a) Born alive and now living. Stillborn ..... Born alive but now dead..... FULL MAIDEN Residence (Usual place of abode). Residence (Usual place of abode) If non-resident, give place and State -It non-resident, give place and State Age at last Birthday 4 Birthplace ...... Birthplace ...... (City and State or County) WITH (City and State or County) Vansleve Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE® each Born alive PLAINLY I hereby certify that I attended the birth of this child, who was | Stillborn on the date above stated. (Signature) \*Where there was no attending physician WRITE or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

ECORD 'EXACTLY, PHYSICIANS of statement of OCCUPA-	PLACE OF DEATH  PLACE OF DEATH  County of City	C WELFARE FATISTICS DEATH State File No
NENT REC	(a) Residence. No. 2 4 0 5 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	11
DING A PERMANENT RECORD should be stated EXACT erly classified. Exact state	PERSONAL AND STATISTICAL PARTICULARS  8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)	MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  (Month) (Day) (Year)
BIN IS AGE Prop	5a. If married, widowed, or divorced HUSBAND of (or) WIFE of	17. I HEREBY CERTIFY, That I attended deceased from
SVED FOR INK—THIS supplied. It may be it fificate.	7. AGE Years Months Days If LESS than 1 day, hrs. or min.	and that death occurred, on the date stated above, at. m.  The CAUSE OF DEATH* was as follows:
RESERVED DING INK- efully supp so that it m of certifica	8. OCCUPATION OF DECKASED  (a) Trade, profession, or particular kind of work	Still Born
GIN NFA e car rms, r	(b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer	(duration) yrs. mos. ds.  CONTRIBUTORY (Secondary)
MA WITH should plain 1	9. BIRTHPLACE (city or town). (State or country)	(duration) yrs. mos. ds.  18. Where was disease contracted if not at place of death?
re PLAINLY, if information of DEATH in ant. See instru	10. NAME OF FATHER  11. BIRTHPLACE OF FATHER (city or town)  (State or Country)	Did an operation precede death? Date of Was there an autopsy?  What test confirmed diagnosis? (Signed) . M. D.
E - 5	11. (State or Country)  12. MAIDEN NAME OF MOTHER Marie Search	1/22, 1930 (Address) reco-slow Islate
CAT im	18. BIRTHPLACE OF MOTHER (city or town)  (State or Country)	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  19. Place of Burial, Cremation, or Removal  Date of Burial
3.—Every Id state ( V is very	Informant (Address) Lewiston Julio.	Mew Slow Flate 1/23 1930  Millertaker Address
N. B. should TION	Filed Jan 1 , 1930 Susan & Dauce Registrar	1 From - W mu le New You hale

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10 948H18 Registration Metric No......State File Prior Registrer No. Local Benisters No. ..... GIRY OF AMERICA in shape, spenium in word 'Billou's' for name in 190 21821 th olasti. Dirid. to the said to descript the brammete of the prophylacia, was used to makeur Ophtheln in Nemeterini? La debt were 100 avan a toll ... amaiki MANTA JII. Besidence Land place of alcole descriptions Harbien- II Ages at last firetaries . . . Color or roce . . . Ages at Last Bletaday Birthillace golfagness) PROTECT OF ALTOTACINA WILLIAM OF ALBERTAL Entrangled the birth of this chifd, who was on the Miller householder,

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RECEIVED MAR PLACE OF DEATH

## DEPARTMENT OF PUBLIC WELFARE

## BUREAU OF VITAL STATISTICS

County	of Waa	
lity of	Doise	Registratio

CERTIFICATE OF DEATH

State	File	No.	 6-9	41	<del>L-0</del>	<b></b>

DO NOT WRITE IN THIS SPACE

Primary	Registration	District No//	004	Α.	Local	Registrar's	No.
(No	172	District No	we	//	)	de	

(140	0.	
of death occurred	d in a hospital or institution, give its name instead of street and nu	mber.)

2. FULL NAME (a) Residence, No.

(If nonresident give city or town and State.) (Usual place of abode.) mo3. How long in U. S. if of foreign birth? dз. Length of residence in city or town where death occured. mos.

PERSONAL	AND	STATISTICAL	PARTICULARS

COLOR OR RACE Single, Married, Widow d. or Divorced (write the word.)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE If LESS than 1 day, Years Months Days .....hrs. or ...min.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work.

(b) General nature of industry. business, or establishment in which employed (or employer)

(c) Name of employer

(State or Country)

PARENTS

item o

FE PLAINLY, —Every item

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER 11. BIRTHPLACE OF FATHER (city or town)

13. BIRTHPLACE OF MOTHER (city or town). (State or County)

14. Informant (Address)

Registrar.

MEDICAL.	CERTIFICATE	OF	DEATH
----------	-------------	----	-------

16.	DATE OF DEATH (Month)	/5 (Day)	19 <b>3</b> (Year)

HEREBY	CERTIFY, That I	ttended doceas d f	rom
1.1.15	1030	" tel !	5 130
	CERTIFY, That I s	Borga	ノッスへ
that I last saw l	A sive on		24500

and that death, occurred, on the date stated above, \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) which ACCIDENTAL SUICIDAL or HOMICIDAL.

Where was disease contracted

if not at place of death? Did an operation precede death?

Was there an autopsy?. What test confirmed

(Signed) Date of Burial

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\* DEATH SEC. SA GAR THUS OF PURCE & 10 Å

A-S	STATE OF	DAHO
AP.	TEC DEPARTMENT OF PU	BLIC WELFARE DO NOT WRITE IN THIS SPACE
Į ŽŽ	PLACE OF DEATH 5 0 1930 BUREAU OF VITAL	STATISTICS
- <del></del>	CERTIFICATE (	OF DEATH State File No
Ħ, P	County of Registration District No	2
ıt, I	City of Primary Registration Dis	Local Registrar's No.
LY	11 001	Maria Maria
ECORD EXACTLY ct stateme	(No	e its name instead of street and number.)
		n6 B
RECORD EXACT	2. FULL NAME Javy Warne	ZVF 10
75.73	(a) Residence. No. 303 January	
tat.	(Usual place of abode) Length of residence in city or town where death occurred. yrs. mos.	(If nonresident give city or town and State) ds. How long in U. S., if of foreign birth? yrs, mos. ds.
NG PERMANENT hould be state y classified. E	PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH_
G ERMAN uld be classifi	8. SEX 4. COLOR OB RACE 5. Single, Married, Widowed	
NG PERI hould y class	Male White or Divorced (write the word)	Malerated + getien 26 30
		(Month) (Day) (Year)
BINDI IS A AGE s properl	5a. If married, widowed, or divorced HUSBAND of	17 I HEREBY CERTIFY, That I attended deceased from
BIN IS IGE Prop	(or) WIFE of	- lan 26 1936 to lan 26 1930
R 1 IS A e p	6. DATE OF BIRTH (month, day and year)	that I last saw hatta aire on Mann 19
FOR THIS ed. A	7. AGE Years Months Tys If LESS than 1	
	Still Born min.	The CAUSE OF DEATH was as those
RVEI INK supp it n	8. OCCUPATION OF DECEASED	Analosally has berten later
ER S	- ·	of Mattern & Dogwature
沒 乙 言字。	(a) Trade, profession, or particular kind of work	Therewise of Alaputa
R LD S	(b) General nature of industry,	7.
ZZRZ	business, or establishment in which employed (or employer)	(duration) yrs. mos. ds.
RGI UNE be c	(c) Name of employer	CONTRIBUTORY
4 L L 2 6	7 ' 7 .	- Mother Oduration Mylhamore de
M. WITH Should plain iction	9. BIRTHPLACE (city or town)	
sh sh nct		18. Where was disease contracted Bould Salar
NLY, trion f TH in instru	10. NAME OF FATHER albina Sabala	Did an operation precede death Date of
		Was there an autopsy?
PLAI form DEA' See	11. BIRTHPLACE OF FATHER (city or town)	What test confirmed diagnosis?
	11. BIRTHPLACE OF FATHER (city or town) (State or Country)  12. MAIDEN NAME OF MOTHER (City or town)	(Signed) M. D.
TE OF	12. MAIDEN NAME OF MOTHER (2.0	(Address)
WRITE m of i JSE OF	vu ac naverai	The state of the s
WRITE item of i	18. BIRTHPLACE OF MOTHER (city or town)	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
רז	(State or Country)	whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
	14. Informant allomo Sabala	19. Place of Burial, Cremation, or Removal Date of Burial
-Ever state is ver	(Address) Bains 1d	St. Johns Cemeters 1/28 1030
\:_	15. / 2. 30 TIN Displa	20. Undertaker Address
ioule Ioule	Filed / -30, 1930 Registrar	Specific & M. Caux Bone, Low
Z = E	Registrar	11 1 1/1000

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Broth STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of..... BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH RETURN (If born in hospital or institution Prim. Registration District No...2/4/Local Registrar's No.../2/2/ give name.) FULL NAME OF CHILD.. (If stillborn, substitute the word "Stillbirth" for name of shild) Number Twin Date of Legiti-Sex of in order Triplet and mate? Med birth Child or other? (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead......Stillborn ..... FULL MOTHER FATHER MAIDEN FULL NAME Aga NAME ... Residence (Usual place of abode) Residence (Usual place of abbde) If non-resident, give place and State.... It non-resident, give place and State... Lita Age at/last Birthday 26 at/last Birthday 26 Birthplace .... (City and State or County) (City and State or County) Occupation .... Occupation Mauseum CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* Born alive on the date above stated. (Signature) \*Where there was no attending physician? (Physician or midwite) or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Registrar.

The second secon Curtain Control Street Tolonier . (In the same of the same of the same of the same The medical was read to prevent the Male in President many and as the ment of the ment of the state of the stat Early slave trat more dead..... Conteste | real place | which to the medical parts de la contrata and had made made made TOTAL TELEVISION OF THE PARTY O Consideration . CONTONOCEDE APERCANDO PROMINENTO CON MENUED 16 million to the state of the on the tree where stated. Low here there was an attending physician Labrellon to nelolen (M. diwife, then the lauger, householder, singil make this refers & stillborn one that seither breathes nor heavs other evidence of life after birth.

STATE OF IDAHO RECEIVED MAR 12 1930 stated EXACTLY, PHYSICIAN d. Exact statement of OCCUPA DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No..... County of. Registration District No...... Local Registrar's No. 576 6 City of (No. 🚣 PERMANENT RECORD or institution, death occurred in a hospital name instead of street and number.) 2. FILL NAME Residence. No..... (Usual place of abode) (If nonresident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. di Length of residence in city or town where death occurred. AGE should be st properly classified. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS qux Single, Married, Widowed 16. DATE OF DEATH COLOR OB RACE or Divorced (write the word (Month) (Day) (Year) If married, widowed, or divorced HUSBAND of AGE 17. I HEREBY CERTIFY, That I attended deceased from (or) WIFE of 6. DATE OF BIRTH (month, day and year) 7. AGE If LESS than 1 day. Years supplied it may tificate. and that death occurred, on the date stated above, at ... The CAUSE OF DEATH\* was as follows: 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer) CONTRIBUTORY (c) Name of employer (Secondary) (duration) should plain ction 9. BIRTHPLACE (city or town 18. Where was disease contracted (State or country) if not at place of death? information F DEATH in t. See instri 10. NAME OF FATHER Did an operation precede death? Ar Date of Was there an autopsy? ... 11. BIRTHPLACE OF FATHER What test confirmed diamos (State or Country) of in OF y item of in CAUSE OF y important. 12. MAIDEN NAME OF MOTHER \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE OF MOTHER (State or Country) 14. 19 Place of Burial, Cremation, state is ver Date of Burial Informant (Address Undertaker ZOL 770

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer. Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications. as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

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DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

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STATE OF IDAHO IN CLOO must be mad DEPARTMENT OF PUBLIC WELFARE RECORD County of. BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No. State File No. (If born in hospital or institution Prim. Registration District No. 21. Local Registrar's No. 76 55 give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number Date of. Sex of and ₹ in order Leziti-Tripletbirth .... Child > or other? (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth...... (a) Born alive and now living. Born alive but now dead Stillborn Stillborn FATHER MOTHER FULL Residence (Usual place of abode) If non-resident, give place and State It non-resident, give place and State While Age at last Birthday. Color or racel Lule Age at last Birthday 2 (Years) Birthplace ... (City and State or County) (City and State or County) Occupation ( ) Occupation . CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* Bern alive I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. \*Where there was no attending physician? or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Registrar.

THE THE WAY TO SERVICE THE the state of the s Prince Clorestry from Easing Str. The state of a state o -Ulama The state of the s the relative between the same of the same wield make here with midd (1) the same actions and the billion of the same IFTHEHHIB. The same of the sa and the second second second second second second Heritages I level place & alegh .... The sector of th The second secon Total Service Control of the Control Birtholuce .... Terlinos - want for La Contraction and a second CHARTEL SATE OF ACTIVITIES OF MEASURE OF MEASURE SATE A procedure to the first the botton of the child who was the contract of THE CALL STREET, SECOND The second secon (mable de nationalis de envertint y sever de t brancher in a seem or markets that the father heupeledge. shouthe A manny the same & sifthorn and an item that neither breather in ddy (sa store office endense of the after birth.

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STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE PLACE OF FEB 14 1930 BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH State File No..... County of Bannock Exact statement of Registration District No..... Pocatello Local Registrar's No..... ENT RECORD stated EXACTLY, Jack McFarland 2. FULL NAME Pocatello. Idaho. (a) Residence. No. (Usual place of abode) PERMANENT (If nonresident give city or town and State)
How long in U. S., if of foreign birth?

Trs. mos. ds Length of residence in city or town where death occurred. AGE should be staproperly classified. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 5. Single, Married, Widowed, or Diverged (write the word) 8. SEX 16. DATE OF DEATH 4. COLOR OR RACE 2. 1930. Fehuary Male White (Month) (Day) 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of LHEBEBY CERTIFY, That I attended decease from SI THIS 6. DATE OF BIRTH (month, day and year) Febuary 2. 1930. 7. AGE Years Months If LESS than 1 day. Days may and that death occurred, on the date stated above, at... hrs. or Still Born 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... None (b) General nature of industry. business, or establishment in which employed (or employer) Infant (duration) \_\_\_\_\_yrs, \_\_\_\_mos, \_\_\_ds, terms, CONTRIBUTORY (c) Name of employer (Secondary) TH in plain instruction o Pocatello. Idaho. (duration) yrs. mos. ds. plnous 9. BIRTHPLACE (city or town). 18. Where was disease contracted (State or country) if not at place of death? \_ of information OF DEATH in tant. See instru Did an operation precede death? 10. NAME OF FATHER Date of Charles M. McFarland Was there an autopsy? ..... 11. BIRTHPLACE OF FATHER (city or town) PARENTS What test confirmed diagnosis (State or Country) Washington (Signed) ... y item of in CAUSE OF J 12. MAIDEN NAME OF MOTHER Beulah M. Hargrave \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 13. BIRTHPLACE OF MOTHER (city or town)\_\_\_\_\_ (State or Country) Idaho. Inkom. Charles M. MoFarland 19. Place of Burial, Cremation, or Removal Date of Burial Mountain View Cemetery (Address)542 South Garfield Avez/Poga. Ida rION i 20. Undertaker Address Pogatello Arthur W. Hall

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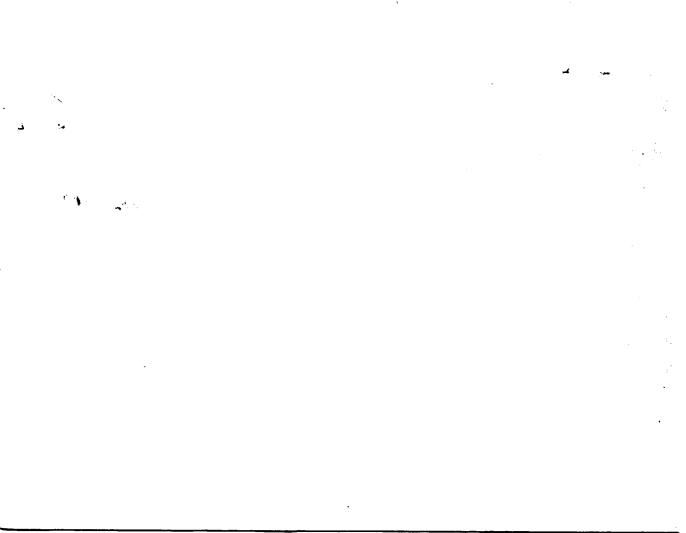
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PLACE OF BIRTH STATE OF IDAHO RECORD be made for 1930 EPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH PERMANENT REFURN must lated. State File No. 178664 Registration District No. (If born in hospital or institution Prim. Registration District No. 2/6/Local Registrar's No. 96 42 give name.) FULL NAME OF CHILD.... (If stillborn, substitute the word "Stillbirth" for name of child) Number Date of Legiti-Sex of Triplet in order ARATE birth Child j or other? mate? (Month) (To be answered only in event of plural births) (Dav) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? SEPA Number of child of this mother, including present birth \_\_\_\_\_\_\_(a) Born alive and now living\_\_\_\_ Born alive but now dead... Stillborn MOTHER FULL MAIDEN UNFADING one child at number of Residence (Usual place of abode) ..... Residence (Usual place of abode) If nonresident, give place and State If nonresident, give place and State Age at last Birthday 65 Age at last Birthday (Years) Birthplace & Birthplace. City and State or Country) (City and State or Country) man Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* 3:50 P. M. I hereby certify that I attended the birth of this child, who was \ Stillborn on the date above stated. (Signature) \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth.



ANS JPA.	RECEIVED FEB 1 4 1930 DEPARTMENT OF PUR	DAHO LIC WELFARE DO NOT WRITE IN THIS SPACE
	FLACE OF DEATH	
PHYSICIAN	County of Bannock CERTIFICATE O	
F of	City of Posatello Registration District No	I can Domintural at 1
r RECORD ed EXACTLY, I Exact statement	(No. Pocatello G	eneral Hospital
OR Staf	(If death occurred in a hospital or institution, give	its name instead of street and number.)
SE EX	2. FULL NAME Infant Daniels (a) Positions No. Posatello. Idah	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
DING A PERMANENT RECORD should be stated EXACT erly classified. Exact state	(I) Nesidence. 140	ds. How long in U. S., if of foreign birth? yrs. mos. ds.
A NI	PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
RM. Id 1 lassi	8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Diverged (write the word)	16. DATE OF DEATH
ING PERI should rly cla	Female White Single	January 11, 1930.  (Month) (Day) (Year)
BINDING IS A PE AGE shou	5a. If married, widowed, or divorced HUSBAND of	17. I HEREBY CERTIFY, That I attended deceased from
BINI IS AGE prope	(or) WIFE of	19
P. HIS	6. DATE OF BIRTH (month, day and year) January 11, 193  7. AGE Years Months Days If LESS than 1 da	_   triat I mat saw ii
	Still Rom	and that death occurred, on the date stated above, atm.
RVED FOUNK—TI Supplied it may	8. OCCUPATION OF DECEASED	The CAUSE OF DEATH* was as follows:
	(a) Trade, profession, or None particular kind of work	høn histeresure on card
_ 4 5 2	(b) General nature of industry, business, or establishment in which employed (or employer)	(duration) yrsds,
ARGIN UNFA be cal terms,	(c) Name of employer	CONTRIBUTORY (Secondary)
_ ≾ખનૂ ∵ુ	9. BIRTHPLACE (city or town) Pocatello, Idaho.	
MAWITH Should plain ction c	(State or country)	18. Where was disease contracted if not at place of death?
MLY, WITH ation shoul [H in plain instruction	10. NAME OF FATHER LAMAR Daniels	Did an operation precede death?
PLAINLY, information DEATH in See instri	11 DIDWINY A CHI O'R PARTITION ( 14 - 1 - 1 )	Was there an autopsy?
Se DEC	(State or Country)  Malad, Idaho,	What test confirmed diagnosis?  (Signed) Ce Ray M. D.
TE OFF	(State or Country)  Malad, Idaho,  12. MAIDEN NAME OF MOTHER Vera Betty Jones	/// , 1851 (Address) Pocatillo
WRITE y iten of i CAUSE OF	13. BIRTHPLACE OF MOTHER (city or town) [State or Country] Idaho.	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
	14. Informant LaMar Daniels	19. Place of Burial, Cremation, or Removal Date of Burial
-Ever state	(Address) Pocatello, Idaho, /	Malad. Idaho. 1/13/30 19
B.—Bald	16. (-12 3b Q/P/1 11)	20. Undertaker / Address
S. Sho	Filed 19 Regrisper	ARTHUR W. HALL POCATELLO

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Do not accept a certificate of death signed only by a

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PA-	RECEIVED MAR 7 1930	STATE OF IDAHO DEPARTMENT OF PUBLIC				
COC	PLACE OF DEATH	TISTICS	DO NOT WRITE I	N THIS SPACE		
PHYSICIAN 1 of OCCUPA	County of Bonner	EATH	State File No	39481		
PH	R die T	-		14		
<b>=</b>	City of Sant Jour	rimary Registration District N	0. 2155	Local Registrar	s No	
ORD ACTLY, statemen	(Te death assumed t	Non a hospital or institution, give its nar	me instead of street and	)	N	
	2 .	7 Buitton	me macau or succe and r	*	20	
REC ract	(a) Residence. No. St.					
a te	(Usual place of abode) Length of residence in city or town where death		(If nonresident give city or town and State)			
N Set E	PERSONAL AND STATISTICAL					
BINDING IS A PERMANENT AGE should be state properly classified. E	84 SEX 4. COLOR OR RACE	5. Single, Married, Widowed,	16. DATE OF DEATH	L CERTIFICATE OF DE	SATH	
	Make White	or Divorced, (write the word)		-el- 12	1970	
	5a. If married, widowed, or divorced	1 -		Month) (Day	, , , , , , , , , , , , , , , , , , , ,	
IS I	HUSBAND of (or) WIFE of	V	HEREBY CERTI	FY, That I attended dece		
7 - 1	6. DATE OF BIRTH (month, day and year)	el 15, 1930	that I last saw h	alive on		
FOR THIS ied.	7. AGE Years Months Da	ys If LESS than 1 day, hrs. or	and that death occurred, on the date stated above, atm.			
ED K	sullow	min.	The CAUSE OF DEATH* was as follows:			
E S IN	8. OCCUPATION OF DECEASED	name	Still	l birth.	in 8 th	
RESE DING efully so tha of ce	(a) Trade, profession, or particular kind of work	one	month of.	Sestation		
~ < # `*	(b) General nature of industry, business, or establishment in		0	(duration) yr	mosds.	
RGIN UNFA be ca erms, n back	which employed (or employer)		CONTRIBUTORY Placeula Praera			
<b>∢+</b> 61		6 1	(Secondary)	(duration)yrı	s. mos de	
MANTTH WITH Should plain ction	9. BIRTHPLACE (city or town)	us porget	18. Where was disease	contracted		
ra in in	10. NAME OF FATHER 🕿 🦟 🕡 🞉	2 12	if not at place of de		f	
NL atio ins	Carl	L. Drittain	Was there an autopsy?	•		
PLAINLY nformation DEATH See inst	11. BIRTHPLACE OF FATHER (city or to	VII)	What test confirmed day	non non		
.=	11. BIRTHPLACE OF FATHER (city or to	re warn	2 - 5 th 19 7	700	, M. D.	
WRITE m of i ISE OF portant	12. MAIDEN NAME OF MOTHER	theen Privers -	<u> </u>	O (Address)	Yim	
WRI item	13. BIRTHPLACE OF MOTHER (city or to (State or Country)	wn) _ / / / / / / / / / / / / / / / / / /	*State the DISEASE CAUSES, state (1) ME	AUSING DEATH, or in C EANS AND NATURE O SUICIDAL, or HOMICI	leaths from VIOLENT	
r3 1	wali					
Every state ( is very	14. Informant Earl JC, 13	rittain	Place of Burial, Cre		Date of Burial	
H 75.81	(Address) Seattle We	ashington.	mecre 7	Cemelly &	1930	
. B. ION	15. Filed Feb. 16 , 1930	yola alles	20. Undertaker Moon / Wo		Address	
Z	L	April Registrar		mary st	merpout de	

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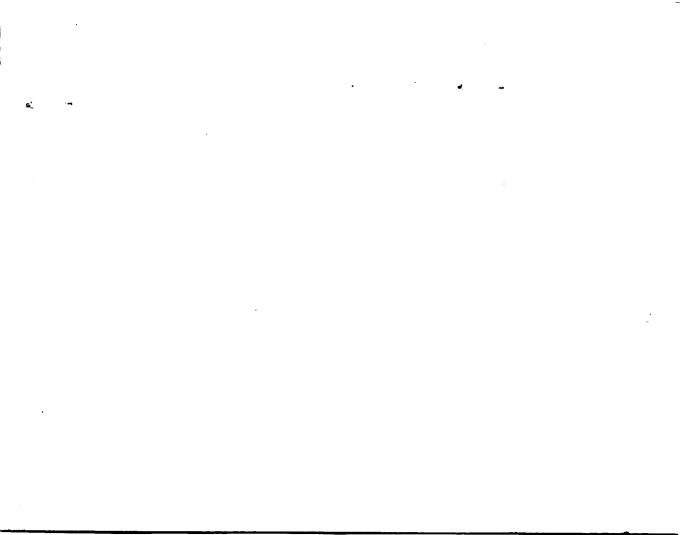
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STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No..... (If born in hospital or institution Prim, Registration District No. 2/55 Local Registrar's No. 2/ give name.) FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of child) Number Twin Date of Sex of Legiti> Triplet in order ATE DE BITT birth mate Child or other? of hirth (Month) (Day) (To be answered only in event of plural births) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum 75 SEP Number of child of this mother, including present birth-(a) Born alive and now living. Born alive but now dead. Stillborn **FATHER** MOTHER FULL MAIDEN UNFADING one child at h Residence (Usual place of abode) Residence (Usual place of abode). If nonresident, give place and State If nonresident, give place and State Color or race Color or race Age at last Birthday. (Years) (Years) Birthplace Birthplace \_ (City and State or Country) City and State or Country Occupation S CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* Rorn aliva I hereby certify that I attended the birth of this child, who was ? Stillborn on the date above stated. 70 (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Registrar.



RECEIVLD MAR STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No ... Registration District No. Exact statement Local Registrar's No..... Primary Registration District No. 4 EXACTLY. (If death occurred in a hospital or institution, give its name instead of street and number.) 2. FULL NAME Residence, No. (Usual place of abode) (If nonresident give city or town and State) Length of residence in city or town where death occurred. How long in U. S., if of foreign birth? yrs. mos. yrs. classified. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS S. SEX COLOR OR RACE 5. Single, Married, Widowed. or Divorced (write the word) (Month) (Year) 5a. If married, widowed, or divorced HUSBAND of HEREBY CERTIFY, That I attended deceased from (or) WIFE of 6. DATE OF BIRTH (month, day and year) 7. AGE If LESS than 1 day, Days and that death occurred, on the date stated above, at. tificate min. The CAUSE OF DEATH\* was as follows: 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work.... (b) General nature of industry, business, or establishment in (duration) .....yrs. ....mos. .... which employed (or employer) termi CONTRIBUTORY (c) Name of employer (Secondary) should ....(duration) \_\_\_\_\_yrs. \_\_\_\_mos. 9. BIRTHPLACE (city or town 18. Where was disease contracted (State or country) if not at place of death? W\_ Date of..... 10. NAME OF FATHER Did an operation precede death?... OF DEATH ant. See inst Was there an autopsy? 11. BIRTHPLACE OF FATHER (city or What test confirmed diagnosis? (State or Country) y item of in CAUSE OF y important. 12. MAIDEN NAME OF MOTHER \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 13. BIRTHPLACE OF MOTHER (city or tawn (State or Country) Place of Burial, Cremation, or Removal Date of Burial Informant (Address) Address

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1930 E OF IDAHO PERMANENT RECORD RETURN must be made for the stated. County of Igomes DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No.... .....State File No..... (If born in hospital or institution Prim. Registration District No. 2/55 Local Registrar's No. 16 give name.) FULL NAME OF CHILD...... (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Date of Legiti-/ Sex of / Triplet in order birth Child Ken or other? mate? (Month) (To be answered only in event of plural births) What prophylactic was used to prevent Ophthalmia Neonatorum?.... -THIS SEPAI order Number of child of this mother, including present birth 3 (a) Born alive and now living Stillborn Born alive but now dead. Cos MOTHER **FATHER** FULL MAIDEN Residence (Usual place of abode) Residence (Usual place of abode) If nonresident, give place and State. If nonresident, give place and State Age at last Birthday Birthplace (City and State or Country) (City and State or Country) Occupation ... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife) WRITE B.—In etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DEPARTMENT OF PREMIS WELFAR BUREAU OF VILLE STREETSTICS CERTIFICATE OF BIRTH State File No. Regis ration District No. ........ Prof. Registration District No.C. than 1 and Registrar's No. ...... What prophylactic was used to prevent Orbibisismin Noonatorum? Sach Number of child of this mother, including property of her RAPPAT Il conrecident, give prace and St. City and Sinte for Couplry) (City and State or Country) CERTIFICATE OF ATTENDING PHYSICIAN OR MIDETER t hereby ourtify that I attended the hirth of this child, who was a Salborn on the date above stated. \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn chitd is one that neither breathes nor shows ather evidence of life after birth.

I.Y, PHYSICIANS ment of OCCUPA-	PLACE OF DEATH  County of Sandpoint  City of Sandpo	C WELFARE ATISTICS DEATH  DO NOT WRITE IN THIS SPACE State File No		
MARGIN RESERVED FOR BINDING WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, I should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instruction on back of certificate.	(No. (No. (No. (No. (No. (No. (No. (No.	St.    St.   (If nonresident give city or town and State)		
	9. BIRTHPLACE (city or town)  10. NAME OF FATHER Charles Bonar  11. BIRTHPLACE OF FATHER (city or town)  (State or Country)  12. MAIDEN NAME OF MOTHER Ossie Colville  13. BIRTHPLACE OF MOTHER (city or town)  (State or Country)  14. Informant Charles Bonar  (Address) Manspoint, Ja  15. Filed 7th. 16, 1930.  16. Filed 7th. 16, 1930.  17. Registrar	18. Where was disease contracted if not at place of death?  Did an operation precede death?  Was there an autopsy?  What test confirmed diagnosis?  (Signed)  (Signed)  (Signed)  (Address)  (Address)  (Signed)  (Signed)  (Signed)  (Address)  (Address)  (Address)  (Signed)  (Signed)  (Signed)  (Signed)  (Address)  (Address)  (Signed)  (Signed)  (Signed)  (Address)  (Address)  (Signed)  (Signed)  (Signed)  (Address)  (Signed)  (Signed)  (Address)  (Signed)  (Signed)  (Signed)  (Address)  (Signed)  (Signed)  (Address)  (Signed)  (Signed)  (Signed)  (Address)  (Address)  (Signed)  (Signed)  (Address)  (Address)		

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5	PLACEFRECHERINE D MAR 6 1930	STATE OF IDAHO					
RECORD be made fo	County of Cocce	RTMENT OF PUBLIC WELFARE UREAU OF VITAL STATISTICS					
	City of Crofus Ida, = =	CERTIFICATE OF BIRTH					
22	No St.	1 T Q Q Q P					
	Mandanidanation development della conservation con conservation con conservation con contract con contract con contract	ACC NOState File No					
	(If born in hospital or institution give name.)  Prim. Registratio	n District No.2/57 Local Registrar's No.20					
PERMANENT REFURN must h th stated.	FULL NAME OF CHILD Arman						
	(If stillborn, substitute the word "Stillisirth" for name of child)						
TE R birth	Sex of Triplet and in order of birth	Legiti- mate? 4 birth 17 19.30					
ATA	(To be answered only in event of plural bi						
A P B	What prophylactic was used to prevent Ophthalmia Neonatorum?						
H H H	Number of child of this mother, including present birth	(a) Born alive and now living					
	Born alive but now dead	Stillborn					
Z f d	NAME CISA B FATHER NAME CISA DE CINADIET DE	MAIDEN STATUS SEEC &					
S E C	Residence (Usual place of abode)	Residence (Usual place of abode)					
UNFADIN ne child at number of	If nonresident, give place and State.	If nonresident, give place and State					
194	Color or race Age at last Birthday	Color or race Age at last Birthday 44					
	Birthplace (Years)	Birthplace (Years)					
日記	Occupation (City and State or Country)	Occupation (City and State or Country)					
F 4 5	CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*						
	I hereby certify that I attended the birth of this child, who was Stillborn at 100 M.						
	on the date above stated.	sture) Senedict h					
PLAIN ase of	(Signature)						
교통	*Where there was no attending physician	(Oather)					
	or midwife, then the father, householder,	Madi Od Co					
WRITE B.—In	etc., should make this return. A stillborn Addre	:58 CCO 7 3 2 2 CCO					
Z.	shows other evidence of life after birth. Filed.	19 15-1 Macci					
		Megistrar.					

II

. . . 

RECORD I EXACTLY, PHYSICIANS Exact statement of OC-	Cit;	PLACE OF DEATH  County of Courted in a hospital or institution, give its name instead of street and number.  (If death occurred in a hospital or institution, give its name instead of street and number.)  (It death occurred in a hospital or institution, give its name instead of street and number.)  (It death occurred in a hospital or institution, give its name instead of street and number.)  (If nonresident give city or town and State)  Length of residence in city or town where death accurred vis. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.						
IE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT E, of information should be carefully supplied. AGE should be stated Is OF DEATH in plain terms, so that it may be properly classified. imnortant. See instructions on back of certificate.	3,5	personal and statistical particulars  Personal and statistical particulars  4 color or race or Divorced, (write the word)  If married, widowed, or divorced HUSBAND of (or) Wife of	MEDICAL CERTIFICATE OF DEATH   16 DATE OF DEATH   1930   (Month) (Day) (Year)   17   I HEREBY CERTIFY, That I attended deceased from   19   19   19   19   19   19   19   1					
	7.	DATE OF BIRTH (month, day and year)  GE Years Months Days If LESS than 1 day,hrs.  OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer	that I last saw h alive on					
	PARENTS	10 NAME OF FATHER E. Ber redict for State or country)  11 BIRTHPLACE OF FATHER (city or town)  (State or country)  12 MAIDEN NAME OF MOTHER (city or town)  (State or country)	(duration) yrs. mos. ds.  18 Where was disease contracted if not at place of death? Date of Was there an autopsy?  What test confirmed diagnosis? M. D. (Address)  *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL. or HOMICIDAL.					
/フSタタケ WRI N. B.—Every item should state CAUSI CUPATION is very	14	Informant E. B. Benedist July (Address)  Filed 117, 1930 11-11 Thank	19 Place of Burial, Cremation, or Removal  19 Place of Burial, Cremation, or Removal  20. Undertaker  Address  Address					

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PLACE OF BIRTH STATE OF IDAHO RECORD DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH No. Registration District No. 27 State File No. (If born in hospital or institution Prime Registration District No. 2//7 Local Registrar's No. give name.) FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number Sex of Triplet Legiti-Date of Child or other? birth mate? (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth..... (a) Born alive and now living...... Born alive but now dead......Stillborn \_\_\_\_\_ FULL MAIDEN NAME O number Residence (Usual place of abode) To catello Sta It non-resident, give place and State. If non-resident, give place and State Color or race. Color or race W ku (Years) Birthplace .... Birthplace ..... Sity and State or County) (City and State or County) Occupation Frank Occupation Houseurfe CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was | Stillborn on the date above stated. (Signature) \*Where there was no attending physician WRITE or midwife, then the father, householder, Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor! shows other evidence of life after birth. Registrar.

Print Perintends Thanker to a few Trans The French No. The same of the sa nedrinera i bern Lecit Mittald to Colum. tal mountaining new med to present (phahelonin Vernaturum) have I wan the ment of the ment of the control of t Beer ally but now dead Horidence United place of about 1 and 1 - 42 The state of the same the statement with the base and the tr Charles Incl Id and and the second idetical and in the winted to etch tagent IVI BOY TO AME DOG TELL nell godine. Occupation Action CREWERLATE OF ATTAMBING PRESICIAN OR MERVIER. thereby courte that a niceded the birth of this child, who was building Detelle priods of the distant Palebourer whiter there was no astending physician or follow ite. then the futher, thousehulden and the second second etc. should make this cours. A stillborn durid to one that politics broatline nor Above rotter wilderen of Mender hirth.

LY, PHYSICIAment of OCCU	PLACE OF DEATH  County of Tranklin  City of Tustom Sda  Registration District No	DO NOT WRITE IN THIS SPACE State File No. 69571  Local Registrar's No.
MARGIN RESERVED FOR BINDING  [TE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT REC of information should be carefully supplied. AGE should be stated EX OF DEATH in plain terms, so that it may be properly classified. Exact ant. See instruction on back of certificate.	(If death occurred in a hospital or institution, give its a construction of the constr	
WR] N. B.—Every item of the should state CAUSE	14. Informant CAddress)  15. Filed Feb. 27, 1930  16. Registrar	whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  19. Place of Burial, Cremation, or Removal  Date of Burial  2 - 2 / 19 3 c  20. Undertaker  Address

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1930 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of ... BUREAU OF VITAL STATISTICS City of..... CERTIFICATE OF BIRTH Registration District No. .State File No..... (If born in hospital or institution ocal Registrar's No.... give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of shild) Number Sex 4 Date of Legiti-Triplet in order birth or other? of birth (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth Born alive and now living. Born alive but now dead FULL NAME Residence (Usual place of above Residence (Usual place of abode) It non-resident, give place If non-resident, give place Color or race... Color or pac (Years) Birthplace ...... Birthplace Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth.

distribution of the party and the to MITTE ( Philips nessent of mile is obest of parel bistant security state need to prevent Spatibilities Vecalizations makes of childs this mother, including present high the season of the airs and not halp The same dead the same of the The state of the s The standard of the standard o The second state of the second Total but her the see her but her The same of the sa Mrthelm ... propression T. Section not multiple TITLEMENT BO STREET DESCRIPTION OF BILLIANS THE PARTY OF I become could that I attended the birth of this child, who was a sufficient out the time inhore standed. feduration (F) Where these sea attending obreicing his midwift, this taken householder, should uself the return A stilleon HAS AND ROOM TOLLING AND ANY ANY ANY and rules are to something with the

VNS OC- ,		RECEIVED MAR 6 1930	STATE OF ILL DEPARTMENT OF PUBLIC BUREAU OF VITAL S	C WELFARE PATISTICS	DO NOT WRITE IN THE State File No.	HIS SPACE
PHYSICIANS ement of 0C-		9-12	CERTIFICATE OF Registration District No	1.4	Brace File Mo	
rsi(	C	ounty of AMM	Primary Registration Distric	t No. 2/44	Local Registrar's No	
PH	C				)	
Y, 1 ate		It god the Oppur	ed on a hospital or institution,	give its name instead i	nstead of street and number.)	all
PH #	2	FULL NAME Still Burn	th) gaus	DU		
ECORD EXACTLY, PHYS Exact statement		(a) Residence. No		St.	nonresident give city or tow	n and State)
RECORI EXACT Exact	L	(Usual place of abode) ength of residence in city or town where	death occurred yrs. mos.	ds. How long in U. S.	f nonresident give city or tow, if of foreign birth? yrs.	mos. ds.
~'85±.	-	PERSONAL AND STATISTIC	CAL PARTICULARS		CERTIFICATE OF DEATH	
AN De Bass	3	SEX 4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)	16 DATE OF MATH	, 20.	<u>3</u> o 、
F 70	-	- Male I made I	- mjaur	(Month)	(Day)	(Year)
3 20 5	5	ia If married, widowed, or divorced HUSBAND of (or) WIFE of		17 S. HEREB	Y CERTIFY, That attended	deceased from
	-	B DATE OF BIRTH (month, day and year	<u> </u>	that I last saw he	alive on the	19
, 29 . P #	11-		ays   If LESS than	and that death occurre	on the date stated above,	at m.
Bay Gara	_	still born	O   1 day,Ohrs. ormin.	The CAUSE OF TEAT	He was as follows:	
┇┖ ┇┸┇	- 11	OCCUPATION OF DECEASED		164	wier & Kreach	
G IN Illy s that		(a) Trade, profession, or particular kind of work		to she sel	utation).	
2 4 7	11	(b) General nature of industry, business, or establishment in			(duration) yrs	mos ds.
ADING Carefull S, so the	- 11	which employed (or employer)		CONTRIBUTORY		
UNFADIN UNFADIN   be careft terms, so terms, so		(c) Name of employer		(Secondary)	(duration) yrs	mos ds.
9 . 2 . 5	TAC TAC	9 BIRTHPLACE (city or town)	rog Ida	18 Where was disease if not at place of d	contracted	
_ m _	- 11	10 NAME OF FATHER	1 1	Did an operation prece	de death? Date of	
N H S	3	Toenry &	ohn Hanson	Was there an autopsy	1/ /2///.	
PLAINLY, 'information' DEATH in		(State or country)	Mussouri	(Signed)	angels of the	Cery, M.p.
	1001	12 MAIDEN NAME OF MOTHER	lred Dimmeck	TO DISTRIBUTE 19.	CAUSING DEATH, or in de	eaths from VIO-
E 7.7	very 11	13 BIRTHPLACE OF MOTHER (city (State or country)	or town) Perur	LENT CAUSES, state	(1) MEANS AND NATUR DENTAL, SUICIDAL, or HO	E OF INJURY,
e d	23	14 Informant A. J. Da	uson	19 Place of Burial, Cr	emation, or Removal D	ate of Burial
Every state (		(Address) Zrg	y Ida	Tresidal	a cere 5-	ddress
N. B.— should	CUFATION	15 Filed Feb 20, 1930 Lie	ey m Puckers	20. Undertaker	Rickerd 2	roy I da
Z 43 5	∥د					/

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Do not accept a certificate of death signed only by a midwife.

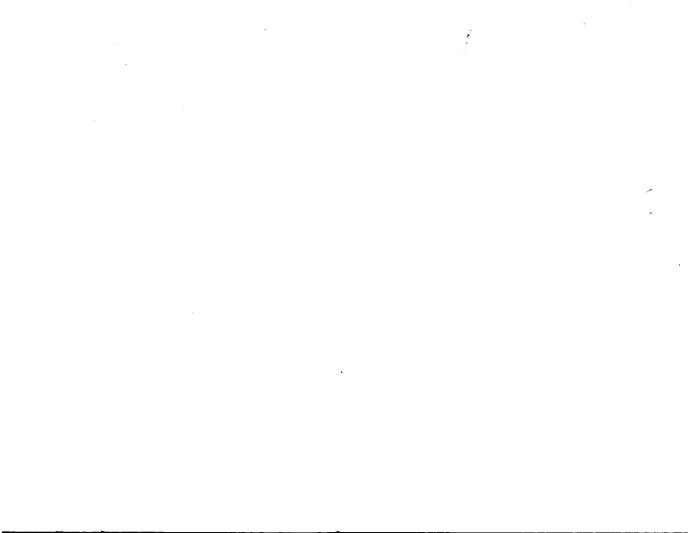
STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County BUREAU OF VITAL STATISTICS City of... CERTIFICATE OF BIRTH PERMANENT RETURN must Registration District No..... State File No. (If born in hospital or institution Prim. Registration District No. 2/// Local Registrar's No. give name.) RETURN Skilling (If stillborn, substitute the word "Stillbirth" for name of child) FULL NAME OF CHILD. Number Date of Sex of Legiti-Triplet in order birth Child or other? of hirth mate? (To be answered only in event of plural births) (Month) What prophylactic was used to prevent Ophthalmia Neonatorum? SEP Number of child of this mother, including present birth (a) Born alive and now living. Born alive but now dead. Stillborn æ.E FATHER MOTHER FULL each. MAIDEN Residence (Usual place of abode) Residence (Usual place of abode). If nonresident, give place and State. the number If nonresident, give place and State ge at last Birthday. Age at last Birthday. Color or race Color or race Birthplace Birthplace. (City and State or Country) City and State or Country) Occupation Occupation and CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* more Born alive-I hereby certify that I attended the birth of this child, who was i on the date above stated. ö (Signature) case \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Day)

(Years)

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RECORD be made for STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS City of CERTIFICATE OF BIRTH PERMANENT | RETURN must be the stated. Registration District No..... (If born in hospital or institution Prim. Registration District No 2013 Local Registrar's No 32 give name.) FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of child Twin Number Sex of Date of Triplet Legitiin order THIS IS A SEPARATE I order of birtl Whirth Me Child or other? of birth mate? (To be answered only in event of plural births) (Month) (Day What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present hirth (a) Born alive and now living Born alive but now dead... Stillborn MOTHER birth each, FULL MAIDEN UNFADING one child at bi number of ea Residence (Usual place of abode) Residence (Usual place of abode) If nonresident, give place and State If nonresident, give place and Stat Color or rac ge at last Birthday at last Birthday one (Years) Birthplace Birthplace City and State or Country (City and State or Country) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFFS more ch an PLAINLY I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder. etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Registrar.



Alex Boston State Parket No. 10 THE OF CHILD the subsection of the state of and mobile in the same to pearent distribute Xeonathrous? fines allye but bear dead where to make them it would be bone to make (cold) musticed trementaries and place place and the services accommon to Some resident print plant and Blat. redaired that in and the court of pair of ARREST TOTAL BUTTHURY. Cultur Printers a bundanting tanger to state the wife merangulati. CHAPTER OF ATTENDING PRIMARIES OR MINERS. water on his Physola corder that I attended the birth of this child, who was followed on the date shad salend. (Stulentill) Custolered and con a tending the contraction Chydlen or ind went or pildwife then the fother householder. ele, should anke this return a stillern 893**5**6/. child is one that actiber breathes nor fatigues other evidence of the after pirth

1	RECEIVED MAR 1 0 1930	STATE OF IDA	но	
		DEPARTMENT OF PUBLI		DO NOT WRITE IN THIS SPACE
-	PLACE OF DEATH	BUREAU OF VITAL ST		COCOO
Co	ounty of west all	CERTIFICATE OF		State File No
Ci	ty of/4	Registration District No		Local Registrar's No
	· · · · · · · · · · · · · · · · · · ·	Primary Registration District	No 7	
	(18 Jack)	(No	roand instead of street and	( 10 mm/s 1 mm/s
	` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `	7, 0	hame histar ja su eet and	, number.)
2.	FULL NAME	ing nec	cary	,
#	(a) Residence. No(Usual place of abode)	Rely		(If nonresident give city or town and State)
L	ength of residence in city or town where de	ath occurred. yrs. mos. ds.	How long in U. S., if	of foreign birth? yrs. mos. ds.
	PERSONAL AND STATISTIC	CAL PARTICULARS	MEDIC	AL CERTIFICATE OF DEATH
3.	SEX 4. COLOR 93 RACE		16. DATE OF DEAT	TH.
6	male ulliste	or Divorced (write the word)		2 - / 4
58	a. If married, widowed, or divorced			(Month) (Day) (Year)
	HUSBAND of (or) WIFE of		17. 1 HEREBY CERT	TIFY, That I attended deceased from
	. DATE OF BIRTH (month, day and y	F/ 11/ 1020	that I last saw h	alive on Sties on 19
11	AGE Years Months	Days H LESS than 1 day,	1	ed, on the date stated above, at 3
ļ		min.	The CAUSE OF DEA	
	. OCCUPATION OF DECEASED	miii.	Julia	- Literie
			the	aul Ti
	(a) Trade, profession, or particular kind of work	<u>``</u>		
	(b) General nature of industry, business, or establishment in			(duration)yrsmos
	which employed (or employer)		CONTRIBUTORY	
	(c) Name of employer	4-	(Secondary)	•
9.	. BIRTHPLACE (city or town)	Tallo da.	18. Where was diseas	, , , , , , , , , , , , , , , , , , , ,
	(State or country)	<del></del>	if not at place of	death?
	10. NAME OF FATHER	I malling.	Did an operation prece	ede death? Date of
	11. BIRTHPLACE OF FATHER (city o	1 / He crang	Was there an autopsy	,?
ENTS	(State or Country)		What test confirmed d	liagposis?
E		Many	2 (Signed)	15-10 Y
PAR	12. MAIDEN NAME OF MOTHER	o Ma Minder	7 7 19	30 (Address)
PAR	18. BIRTHPLACE OF MOTHER AND	or town)	*State the DISEASE	E CAUSING DEATH, or in deaths from VIOLE
H	(State or Country)	Vant Ruser	CAUSES, state (1) I whether ACCIDENTA	MEANS AND NATURE OF INJURY, and L, SUICIDAL, or HOMICIDAL.
1	4. PH A	200/	19. Place of Burial, C	Cremation, or Removal
	Informant of lucin	1 Command	11:0	H 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
-	(Address)	very fra	2 . Weptaker	Abdress
1	5. Filed 3-6 , 19 30 66	Stelly Smile Registrar	(747)	The state of the s
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STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife. Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

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Can't	er maggi <del>raga</del>	des sammen set	Legiti	erester.	nterior de la companya de la company	ULL NAME OF	30
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		N OR HE WEST	oing da kareiv	d the birth of this	CREES Ly thin Lattende		en ground to
Sage States	Modeline on the	in (F)	dress	physican reholder, stillborn tibes for Ad	was no attending en two cotlect has be this octuro. J hat neither bro vidence of life of	et afferster the etc., should ran child is one t	1000 m) 10 m

	PLACE OF DEATH	DEPARTMENT OF PUBUREAU OF VITAL	STATISTICS	DO NOT WRITE	IN THIS SPAC
	PLACE OF DEATH	CERTIFICATE (		State File No	6970
Cou	unty of	Registration District No		<u>.                                    </u>	····
Cit	ty of Case			Local Registr	ar's No
	_	Primary Registration Dist		`	1.
	(If death occur	(Nodd in a hospital or institution, say	its name instead of street a	) ind number.)	
		Carla A The	andre D.		
2.	FULL NAME	-72-7	7		•
	(a) Residence. No(Usual place of abode)		St.	(If nonresident give cit	v or town and State)
Le	ength of residence in city or town where	leath occurred. yrs. mos.	ds. How long in U. S., i	f of foreign birth?	yrs. mos. di
	PERSONAL AND STATIST	ICAL PARTICULARS	MED	ICAL CERTIFICATE OF	DEATH
3/	SEX 4. COLOR OR RAC	E 5. Single, Married, Widowed, or Divorded (write the word)	16. DATE OF DE	ATH	
1	em While	Line word)	4.	1- //	19
5a.	. If married, widowed, or divorced HUSBAND of				Day) (Year
	HUSBAND of (or) WIFE of	4	17. I HEREBY CE	RTIFY, That I attended o	
-	DATE OF DIDENT (	4/2/11-1921	7		, 19
	AGE Years Months	Days If LESS than 1 of	that I last saw he		
''	Teats Months	hrs.	or and that death occu.	rred, on the date stated ab	ove, at
		min.	The CAUSE OF	EATH* was as follows:	roceshalin
8.	OCCUPATION OF DECEASED		and a	hua Kelli	lat
	(a) Trade, profession, or particular kind of work			,	
	(b) General nature of industry,			/ 3	
	business, or establishment in which employed (or employer)			(duration)	yrsmos
	(c) Name of employer	2	CONTRIBUTORY (Secondary)		
	<b>A</b>	11111111		(duration)	yrsnos
9.	BIRTHPLACE (city or town) (State or country)	more, pua	18. Where was disc	ease contracted	
$\vdash$	0.1	41	if not at place of		
	10. NAME OF FATHER	offughes.	Did an operation pr	7///	te of
-		0	Was there an autor	771 11 1	il (
ENTS	11. BIRTHPLACE OF FATHER (city (State or Country)	or town)	What test confirmed	diagnosis?	3/250 -
RE	Muss	our	Signed)		os ca do o
PA	12. MAIDEN NAME OF MOTHER	. Allen	-/17/30,	19 (Address)	
-	13. BIRTHPLACE OF COTHER (city (State or Country)	or town	*State the DISEA CAUSES, state (1 whether ACCIDEN'	SE CAUSING DEATH, or MEANS AND NATUR FAL, SUICIDAL, or HOM	in deaths from VIOL E OF INJURY, and HCIDAL.
14.	Rule Hu	Kal	—	, Cremation, or Removal	Date of Burial
	Informant	1. I la			:
il	(Address)	4.			<del> </del>
<b> </b>			20. Undertaker		Address

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head-homicide; Poisoned by carbolic acid-probably sui-

cide. The nature of the injury, as fractured skull, and con-

sequences (e. g. sepsis, tetanus) may be stated under the

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midwife.

head of "Contributory."

	395 212-001-442
for	PLACE AL BERTH STATE OF IDAHO
KECOKD be made fo	County of APR 1 0 1930 DEPARTMENT OF PUBLIC WELFARE
	City of BUREAU OF VITAL STATISTICS
3 5	CERTIFICATE OF BIRTH
בי בי	No. St. Registration District No. State File No. 75285
	District House File House
	(If born in hospital or institution give name.)  Prim. Registration District No. 1014 Local Registrar's No. 1411
E E E	FULL NAME OF CHILD Still born.
REKMANENT REFFURN must l th stated,	(If stillborn, substitute the word "Stillbirth" for name of child)
EE 4	Sex of Twin Triplet and in order Legitia. Date of 7
<b>₩</b>	Child or other? (of birth (To be answered only in event of plural births) mate? (Month) (Day) (Year)
-THIS IS SEPARAT order of	What prophylactic was used to prevent Ophthalmia Neonatorum?
EPAR rder	
HEL	Number of child of this mother, including present birth (a) Born alive, and now living
'. at 🗏	Born alive but now dead Stillborn Stillborn
i INK birth each, i	FULL V2 C FATHER PAGE 10 MADE NAME OF THE PAGE 11 11 11 11 11 11 11 11 11 11 11 11 11
	NAME NAME MANY WATER
of a	Residence (Usual place of abode) Residence (Usual place of abode)
ald er	If nonresident, give place and State
201	Color or race Age at last Birthday 2 Color or race Age at last Birthday
	Birthplace Octo Teb (Years)
he H	Occupation Occupation Occupation
É É	CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*
are a	Born alive 2 13 9
2 14	I hereby certify that I attended the birth of this child, who was Stillborn at
rLAINLY WITH UNFADIN ase of more than one child at each and the number of	(Signature)
r L.A	
2 2	or midwife, then the father, householder, (Physician or midwife)
3 <b>5</b>	of including the latter, nousellotter,
Z M	child is one that neither breathes nor
ż	shows other evidence of life after birth. Filed 3 1 1930 W. N. K. A. C.
~	Registrar.



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ZZ		COLVED V	IAD 1 1 1930	DED		TE OF IDA			
	R	The state of the s	HILL 10-1			OF PUBLI F VITAL SI	C WELFARE	DO NOT WRITE	IN THIS SPACE
PHYSICIAN of OCCUP.		PLACE OF	DEATH					G. 4 755 33	69408
<b>2</b> 0	Co	unty of A	w	•	CERTIFIC	CATE OF	DEATH	State File No	
₽,₽			- 4	Registr	ation Distr	ict No	Z		61
	Ci	ty of VIOC	2	Primar	v Registrat	tion/District	No. 10,04	Local Registra	r's No.
						7,11	27/11/17		
- <b>25</b> 2	•		(If death occu	No irred in a hos	pital or instit	ution, give its	name instead of greet and	number.)	1.
				* 5	no o		, /	,	$\kappa V$
RECORD EXACTLY, tact statement	2.	FULL NAME.	Jugar		me e	reau	<i>y</i>		
: 'FE 25		(a) Residence	$N_0$ 23	1013	rood	way	St		` '/
at ST	Ta	(Usual place of	of abode town where	death occurre	ed. yrs.	mos. ds.	How long in U. S., if of	If nonresident give city	or town and State)
ANENT be state ified. E		ongon of residence in	City of town where	deadir occurre			1	- Ioleigh bhidh	s. mos. qs.
		PERSO	NAL AND STATIST	FICAL PART	ICULARS		MEDICA	AL CERTIFICATE OF 1	DEATH
NG PERM sould y class	8.	SEX	4. COLOR OR RA	CE 5. Sin	gle, Married, preed (write	Widowed,	16. DATE OF DEAT	116 D	
ING PER] should	ے ا	Kend	mart	e 1 "22	in Al	She word)		Hux- ).	2 <b>3</b> Y
BINDIN IS A P IGE sho properly	58	. If married widow	red, or divorced			<b>1</b>	\ <b>\</b>	(Month) (D	ay) (Year)
E P P P P P P P P P P P P P P P P P P P		I. If married, widow HUSBAND of (or) WIFE of	ou, or unvoiced				17 HEDEBY CERT	IFY, That I attended dec	eased from
BIN IS AGE prop		(OF) WIFE OI					tel 12	, 19 <b>30</b> , to	. 19
70	6.	DATE OF BIRTH	(month, day and yes	ar) when	d- 12-	1930	that I last saw h	alive on	. 19
FOR THIS ed.		AGE Yes		Days	If LESS	than 1 day,	l)	i, on the date stated abov	, <u></u>
				D		hrs. or	The CAUSE OF DEAT		C, BLIII.
RESERVED I DING INK—7 efully supplie so that it may of certificate	_					nin.	THE CAUSE OF DEA	In was as follows:	
Fit a little	8.	OCCUPATION OF	_				10.0	The same	- Home true
SE S		(a) Trade, profes particular kind of	don, or work	20n	l .		- July	10000	J/Grand
N RES FADINC carefull s, so th		(b) General natur	e of industry.		_	•	Cato		
		business, or establ	ishment in					(duration)	7rsds.
医医 《 思路		(c) Name of em					CONTRIBUTORY	ellem	. 07
ا ۾ <del>ن</del> ه ا		(c) Name of em	ployer				(Secondary)		6
MA WITH should plain t ction o	9.	BIRTHPLACE (c	dty or town)	Taise	e e	ادا	pregnan	(duration)	rs ds.
Wr sho pla ctic		(State or country)	ity of wwith				18. Where was disease if not at place of d	e contracted	
		10. NAME OF F.	ATHER O	10	1 4	0 0		de death?Date	
VILY inst			The	it Co	6 mc	Cready	Was there an autopsy		01
	20	11. BIRTHPLACE	E OF FATHER (eity	or town)					1
PLAI nform DEA' See	Z	(State or Cour	itry)		0	٠ . ا	What test confirmed di	agnosis	
.51	PARENTS		"Garjea		ian		(Signed)		$M_{\mathcal{D}}$
WRITE m of in ISE OF portant.	PA	12. MAIDEN NA	ME OF MORHER	1 Elian	Let L.	linkland	192	(Address)	
E E		10 DIDUTTO ACT	e of mother (at		2	- 1	#State the DISEASE	CAUSING DEATH, or in	death and mark
- 2021	Ì	(State or Cour	itry)	or town)	ments	Later -	CAUSES, state (1) M	IEANS AND NATURE L, SUICIDAL, or HOMIC	OF INJURY, and (2)
73 1	<u> </u>	129	1 10 3						IDAL.
	14	Informan	est C	re Cre	ady		19. Place of Burial, Cr	remation, or Removal	Date of Burial
Ever state is ver		(Address) P4	D X 5 13.				marrist	chillen Tun	AL17 1931
		2	21/20	1 Ex	TAV	<del></del>	20. Undertaker		Address
N. B.	15	Filed Z	5, 1920 1	$\mathcal{W}_{\mathcal{N}_{\mathbf{L}}}$	VIW	des	Muller	WY 4 THANKA	Rose Adal
z SE						Registrar	mmm	~ / vug	Down May

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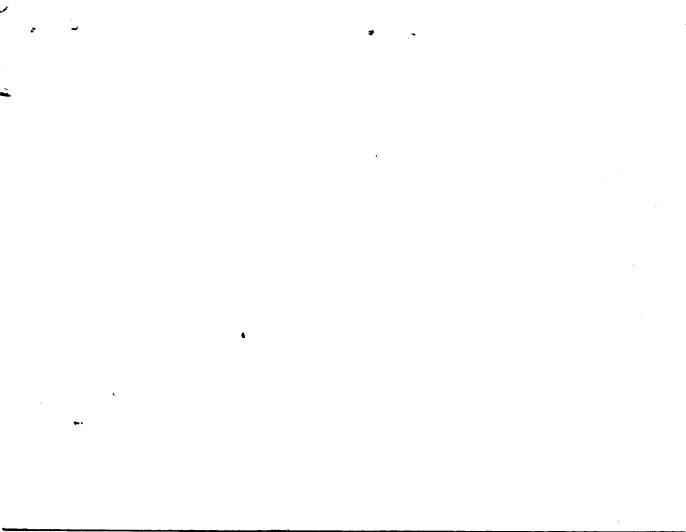
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head of "Contributory."

¥	PLACE RECEIPTED APR 15 1930 STATE OF IDAHO
E fe	County of Sea Jake - = DEPARTMENT OF PUBLIC WELFARE
RECORD be made for	City of Varia BUREAU OF VITAL STATISTICS
E E	CERTIFICATE OF BIRTH
E X	NoSt.
	219 2030(4'236 Registration District No. 23 State File No.
	(If born in hospital or institution give name.)  Prim. Registration District NoLocal Registrar's No
45.4	FULL NAME OF CHUD (LUCE Barkuss
ERMANENT ETURN must stated.	(If stillborn, substitute the word "Stillbirth" for name of shild)
THE STATE OF THE S	Sex of Twin Triplet and Number Legiti- Date of h
<b>₹</b> E	Child percel or other? (To be answered only in event of plural births) mate? (Month) (Day) (Year)
SI Z	What prophylactic was used to prevent Ophthalmia Neonatorum? Wove
AF.	19
	Number of child of this mother, including present birth (a) Born alive and now living
S.E	Born alive but now dead Stillborn Stillborn MOTHER
물속석	FULL (MANGELT (DO a LASA) MAIDEN TO ALLO WALLES
_ E E	NAME OF THE NAME OF THE PROPERTY OF THE PROPER
of a C	Residence (Usual place of abode) Residence (Usual place of abode) Acros Colonia
43 5	If nonresident, give play and state
	Color or race Age at last Bythday Color or race Age at last Birthday 4
Bag	Birthplace Swygerland (Years) Birthplace Swygerland. (Years)
E 돌	Occupation Tax (City and State or Country)  Occupation Tax (City and State or Country)
WITH than	CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*
2 4	5 TO
Fea	I hereby certify that I attended the birth of this child, who was fallborn at at attended the birth of this child, who was fallborn at at attended the birth of this child, who was fallborn at attended the birth of this child, who was fallborn at attended the birth of this child, who was fallborn at attended the birth of this child, who was fallborn at attended the birth of this child, who was fallborn at attended the birth of this child, who was fallborn at attended the birth of this child, who was fallborn at attended the birth of this child, who was fallborn at attended the birth of this child, who was fallborn at attended the birth of this child, who was fallborn at attended the birth of this child, who was fallborn at attended the birth of this child, who was fallborn at attended the birth of this child, who was fallborn at a tended the birth of this child, who was fallborn at a tended the birth of this child, who was fall below at a tended the birth of this child, who was fall below at a tended the birth of this child, who was fall below at a tended the birth of this child, who was fall below at a tended the birth of the birth
PLAINLY age of mo	(Signature) Messey Attach
PL	(*Where there was no attending physician )
-	or midwife, then the father, householder,
WRITE B.—in	etc., should make this return. A stillborn Address Jano
	child is one that neither breathes nor
z	shows other evidence of life after birth.   Filed
-	



A-	FED 1 1 103	STATE OF IDA		
- <b>A</b> E	RECEIVED FEB 1 1 193	DEPARTMENT OF PUBLI BUREAU OF VITAL ST		DO NOT WRITE IN THIS SPACE
	PLACE OF DEATH	CERTIFICATE OF		State File No. 60061
ZHZ of C	County of Dear Take	Registration District No	. <del></del> -	
	City of Jana	Primary Registration District		Local Registrar's No.
T.Y.		(37)		
RECORD EXACTLY, 1	(If death occurred	l in a hospital or institution, give its	name instead of street and	number.)
	2. FULL NAME CAUC	e parquel		70.
75.73	(a) Residence. No	th occurred. yrs. mos. ds.	How long in U. S., if o	If nonresident give city or town and State) of foreign birth? yrs. mos. ds.
NG PERMANENT nould be state y classified. E	PERSONAL AND STATISTICA	AL PARTICULARS	MEDICA	AL CERTIFICATE OF DEATH
XM./ d b assi	8. SEX 4. COLOR OF RACE	5. Single, Married, Widowed, or Divorced (write the word)	16. DATE OF DEAT	H
ING PER should	Female white	A Divoleta (with the world)	Tree!	(Month) (Day) (Year)
ດ ≪ເ	5a. If married, widowed, or divorced HUSBAND of		17. I HEREBY CERT	IFY, That I attended deceased from
BIN IS AGE prop	(or) WIFE of	11-10-22	Feb. 3	, to Frib. 3 , 30
FOR THIS ed.	6. DATE OF BIRTH (month, day and year) 7. AGE Years Months	Days 1 June S the 1 day,	that I last saw hear	alive on
_ ] ## 55 -		fillbull hrs. or		, on the date stated above, at the stated above, at
RESERVED FOR INK—TI efully supplied to that it may	8. OCCUPATION OF DECEASED	min.	Cro Coffee	2 of Umbilical Cord
ER ST	(a) Trade, profession, or particular kind of work			
SES SES	particular kind of work	MINISTER COMMISSION OF THE PROPERTY OF THE PRO		
	(b) General nature of industry.		Acceptance of the backway, response to the contract of the con	(duration)yrsmosds.
UNF UNF be c	(c) Name of employer	, 1	CONTRIBUTORY(Secondary)	
To mE	A	is Idaho		(duration)yrs,mosds.
M. WITH Y, WITH should in plain	9. BIRTHPLACE (city or town) (State or country)		18. Where was disease if not at place of o	e contracted leath?
, a.a.	10. NAME OF FATHER	at Barbaras	Did an operation prece	de death? Date of
NI. TH		Lunterland	Was there an autopsy	Margue & College
PLAI Iform DEA	11. BIRTHPLACE OF FATHER (city or (State or Country)	Way 2	Palfatto	agnosis?
	HE WAYDEN NAME OF WORKER	The local	Feb. 31,	30 (Address) Caris Colales
WRITE IM of i	12. MAIDEN NAME OF MOTHER	me surger		
λ. ##.	18. BIRTHPLACE OF MOTHER (city or (State or Country)	rwary	*State the DISEASE CAUSES, state (1) M whether ACCIDENTAL	CAUSING DEATH, or in deaths from VIOLENT IEANS AND NATURE OF INJURY, and (2) L, SUICIDAL, or HOMICIDAL.
very ate C	14. Informant Candrew B	arrived	19. Place of Burial, Co	
32 9 -Ever state	11		Jana	Totalio Feb. 3 1930
P B B Outled		a feel the man	20. Undertaker	Address
sho s	£1100 p	Registrar	Adurte.	Megherd Paris Ida.

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STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

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Do not accept a certificate of death signed only by a midwife.

mudwire.

PLACE OF BIRTH 49 127 663 163 STATE OF IDAHO  County of DEPARTMENT OF PUBLIC WELFARE  BUREAU OF VITAL STATISTICS  CERTIFICATE OF BIRTH  St.  CIf born in hospital or institution give name.)  FULL NAME OF CHILD  (If stillborn, substitute the word "Stillbirth" for name of child)  Twin  Number
Sex of Triplet or other? and on order of birth mate birth (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum?
Number of child of this mother, including present birth
Born alive but now dead
FULL Clarence Merlys Hurst MAIDE va Marie Johnson
Residence (Usual place of abode) SIGCRIFO Residence (Usual place of abode)
It non-resident, give place and State
Color or race Marie Age at last Birthday 43 ( ) Color or race White Age at last Birthday 28
Pinthulan YO A (16ars)
Occupation City and State or County) Occupation Occupation Occupation
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.
I hereby certify that I attended the birth of this child, who was Stillborn at
*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.  Address  Filed  Registrar.

of old of the state of the stat the colleges an about the colleges of the point of the Andrew of the property of the second of the prophymeth was used to prevent Ophthalida Madnatorum? ..... the of the of this mother tached we present with a the more we and now living House of Lines start of the sta Storie in week, land I) completed ohr mon echilery, sine place of the thing twior or race to the same at last higher Complete test to each . Land Comment to the comment of the comments of the com Pinteplace ... ('The new State or County) The contract of the contract o (ecupation the second CERTIFICATE OF APPRICAME PHYSICIAN OIL MINERE Liberry could distributed the blink of the chief who was stilling destrict ground state will not Signature) Carther these was not attending payers one of sild with, then the father, turnscholder, ote, stouds state this return \ silliborn ron medicand multiple tree the all will be while selfer out to well the stier with

	APD 1.1 soon	- · · · · · · · · · · · · · · · · · · ·	
A-S	APR 1 1 1930	STATE OF IDA	
<b>₹</b> 5		DEPARTMENT OF PUBLICATION	C WELFARE DO NOT WRITE IN THIS SPACE
PHYSICIA of OCCU	PLACE OF DEATH	BUREAU OF VITAL ST	
f o	County of Bannach,	CERTIFICATE OF	
E o	City of June 1801	Registration District No $2$	Local Pagistran's No. 5.797
nen	P	rimary Registration District	No. 2 16
ORD ACTL statem	(If death occurred i	No. Jun 1990	name instead of street and number.)
		+ Hunt	7
REC EX	2. FULL NAME	here la	
F Fed	(a) Residence. No	your now	(If nonresident give city or town and State)
A. sta	Length of residence in city or town where death	occurred. yrs. mos. ds.	How long in U. S., if of foreign birth? yrs. mos. ds.
NG PERMANENT nould be state y classified. F	PERSONAL AND STATISTICAL	PARTICULARS	MEDICAL CERTIFICATE OF DEATH
RM Id Iase	8. SEX 4. COLOR OR RACE	5. Single, Married, Widowed, or Diporced (write the word)	16. DATE OF DEATH
NG PERI hould	Male White	Single	(Month) (Day) (Year)
DI A Erl	5a. If married, widowed, or divorced HUSBAND of		17. I HEREBY CERTIFY, That I attended deceased from
BIN IS AGE prop	(or) WIFE of		3-28 1030 to 3 - 28 1930
FOR THIS ed. A	6. DATE OF BIRTH (month, day and year)	March 28-1930	that I last saw her alive on Stell 19
ID FO C—TH pplied. may l cate.	7. AGE Years Months Da	ys the Ess than 1 day,	and that death occurred, on the date stated above, atm.
		min.	The CAUSE OF DEATH* was as follows:
ERVI G INI ly sul nat it	8. OCCUPATION OF DECEASED	•	
SE S	(a) Trade, profession, or particular kind of work	w	Suy Francisco
RES DIN refull so th	(b) General nature of industry,		
RGIN UNFA be car erms, a	business, or establishment in which employed (or employer)	nl	(duration) yrs. mos.
ARG UN be tern on b	(c) Name of employer		CONTRIBUTORY (Secondary)
	9. BIRTHPLACE (city or town)	1 tille oldahan	(duration) yrs. mos. Jds.
M. WITH Should plain plain	9. BIRTHPLACE (city or town) (State or country)		18. Where was disease contracted if not at place of death?
	10. NAME OF FATHER	Hunt	Did an operation precede death? 24 Date of
	J. 111.	(my	Was there an autopsy?
PLAI forma DEA See	11. BIRTHPLACE OF FATHER (city or to	wn)	What test confirmed diagnosis?
.5.	(State or Country)  (State or Country)  (State or Country)	asi	(Signed) M. D.
VRITE m of i SE OF	12. MAIDEN NAME OF MOTHER	Cohnson	77, 19 74 (Address) 7 35 (Alla
WRITE item of AUSE Ol importan	18. BIRTHPLACE OF MOTHER (city or to	( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
y ite iAU	(State or Country) Muha	rka	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
very ate C	14. Informant 2 m Tu	1	19. Place of Burial Cremation, or Removal Date of Burial
-Ever state	(Address)	2 . 28 - 6 -	Blacks at at de Man Mar 1010 3
227	15.	by	20, Undertaken
lou lou	Filed 724, 1947.	Registrar	15. 8. 11/2 Fani Pacadda.
4 70 (-1			

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midwife.

head of "Contributory."

PLACEREGET WED APR 7 1930 STATE OF IDAHO RECORD be made fo DEPARTMENT OF PUBLIC WELFARE County of.... BUREAU OF VITAL STATISTICS City of Lan CERTIFICATE OF BIRTH Registration District No..... State File No (If born in hospital or institution Prim. Registration District No.2/55 Local Registrar's No.4/ give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of child) Number Date of Sex of Legiti-Triplet in order birth ... Child 3 or other? of birth mate2 (To be answered only in event of plural births) (Month) (Dav) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth. (a) Born alive and now living Born alive but now dead... Stillborn FATHER FIILL MAIDEN Residence (Usual place of abode) Residence (Usual place of abode). If nonresident, give place and State. If nonresident, give place and State. Age at last Birthday Color or race Color or race Age at last Birthday (Years) Birthplace Birthplace\_ City and State or Country (/Citz/ and State or Country) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE® I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth.

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NT RECORD ated EXACTLY, PHYSICIANS Exact statement of OCCUPA-	PLACE OF DEATH  County of Son Control of Management of Public Bureau of VITAL ST CERTIFICATE OF Registration District No.  (If death occurred in a hospital or institution, give its a second of the control of the cont	DO NOT WRITE IN THIS SPACE State File No. 30  Local Registrar's No. 30  name instead of street and number.)  St. (If nonresident give city or town and State)
BINDING IS A PERMANENT IGE should be state properly classified. F	PERSONAL AND STATISTICAL PARTICULARS  8. SEX 4. COLOR OR RACE female  White Single, Married, Widowed, or Divorced (write the word)  Single, Married, Widowed, or Divorced (write the word)	MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  17. 2. 193 • (Month) (Day) (Year)
IN RESERVED FOR I IFADING INK—THIS carefully supplied. A ns, so that it may be I mck of certificate.	HUSBAND of (or) WIFE of  6. DATE OF BIRTH (month, day and year) March 23, 1930  7. AGE Years Months Days If LESS than 1 day, hrs. or min.  8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer	17. I HEREBY CERTIFY, That I attended deceased from  19. 19. 19. 19. 19. 19. 19. 19. 19. 19.
WRITE PLAINLY, WITH tem of information should USE OF DEATH in plain t mportant. See instruction o	9. BIRTHPLACE (city or town) I Coolinai (State or country)  10. NAME OF FATHER  11. BIRTHPLACE OF FATHER (city or town) (State or Country)  12. MAIDEN MAME OF MOTHER  13. BIRTHPLACE OF MOTHER (city or town) (State or Country)  14. BIRTHPLACE OF MOTHER (city or town) (State or Country)	(Secondary)  (duration) yrs. mos. ds.  18. Where was disease contracted if not at place of death?  Did an operation precede death? Date of.  Was there an autopsy?  What test confirmed diagnosis?  (Signed) M. D.  *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
N. B.—Every i should state CA TION is very in	14. Informant L.E. Starr  (Address) Kooteni Ida  15. Filed March 241030. Violy allemants Registrar	19. Place of Burial, Cremation, or Removal  Date of Burial  Date of Burial  Date of Burial  No removal  Address  Output  Address  Sendpoint

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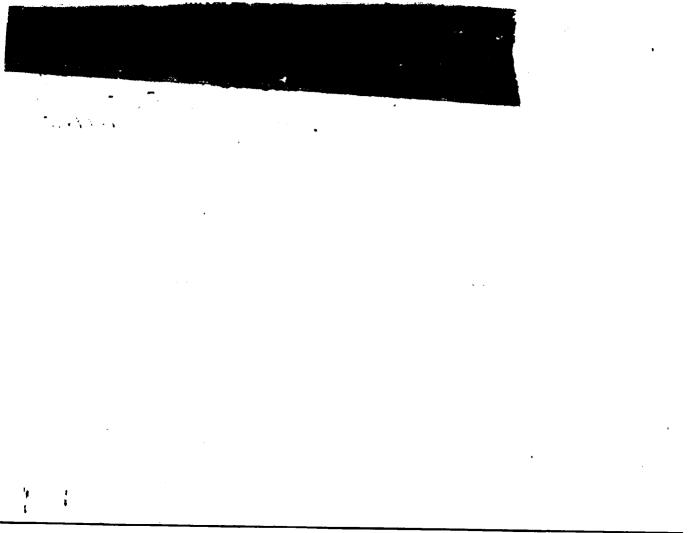
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EXACTLY, PHYSICIANS Exact statement of 0C-	PLACE OF DEATH  County of Registration District No  City of Primary Registration District No  (No. (No. (Usual place of abode) (Usual place of residence in city or town where death occurred yrs. mos.			IS WELFARE TATISTICS DEATH  Ct No. 2005  give its name instead in the sead in	nstead of street and nu	69850 No. 34 mber.)
IS IS A PERMANENT AGE should be stated be properly classified, ifficate.		PERSONAL AND STATISTICAL	1		. CERTIFICATE OF D	193 U
	5a If married, widowed, or divorced HUSBAND of (or) WIFE of  6 DATE OF BIRTH (month, day and year) 7 AGE Years   Months   Days   If LESS than			17 I HEREBY CERTIFY, That I attended deceased from  2, 19 30, to 2, 19 30, to 19 30, t		
fully supplied, that it may a back of cert	7 AGE Years Months Days If LESS than 1 day hrs. or min.  8 OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work  (b) General nature of industry,		The CAUSE OF DEATH* was as follows:  By M. My Way  Specially Malaument			
ITH UNFADIN should be carefi plain terms, so instructions on	business, or establishment in which employed (or employer)  (c) Name of employer  9 BIRTHPLACE (city or town)  (State or country)		(duration) yrs. mos. ds.  CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.  18 Where was disease contracted if not at place of death?			
nformation should DEATH in plain ortant. See instructions	ARENTS	12 MAIDEN NAME OF MOTHER (city or town) (State or country)		Did an operation precede death?		
WRITE P ry item of in CAUSE OF is very impo	14			*State the DISEASE CAUSING DEATH, or in deaths from VIO- LENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
N. B.—Ever should state CUPATION	15	Informant (Address) Pasma, tel	nt, meyes-	Roswell 20. Undertaker  Lather	Comet.	Address Parma -

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) Spinner. (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

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Do not accept a certificate of death signed only by a mid wife.

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2:	A 100 <b>0</b>	STATE OF IDAH	. O		
AP.	RECEIVED APR 4 1930	DEPARTMENT OF PUBLIC		DO NOT WRITE IN THIS SPACE	
<u> </u>	- PLASE OF DEATH	BURĒAU OF VITAL STA	1	69894	
250	County of more	CERTIFICATE OF I		State File No.	
Ħ,a		Registration District No	33		
i i	City of Alluns Terry	Primary Registration District	No. 2021	Local Registrar's No	
LY	(/			) 10	
12 13 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(If death occurr	(No.	name instead of street and	number.)	
RECORD EXACT	2. FULL NAME	Stillborn		'/'	
ENT RECORD stated EXACTLY, PHYSICIAN d. Exact statement of OCCUPA			· Q+		
F 55 83	(a) Residence. No(Usual place of abode)			If nonresident give city or town and State)  f foreign birth?  vrs.  mos.  ds.	
de sta	Length of residence in city or town where de	eath occurred. yrs. mos. ds.	How long in U. S., if o	f foreign birth? yrs. mos. ds.	
NG PERMANENT 10uld be states 7 classified. E	PERSONAL AND STATISTIC	CAL PARTICULARS		L CERTIFICATE OF DEATH	
Z.M. d l ass	S. SEX / 4. COLOR OR RACE	5. Single Married, Widowed, or Divorted (write the word)	16. DATE OF DEAT	70.1.5	
NG PERN hould y class	Males white	Dinale.		(Month) (Day) (Year)	
	5a. If married, widowed, or divorced				
IS 7	HUSBAND of (or) WIFE of	*		IFY, That I attended deceased from	
	3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	10x01/X-1931			
FOR THIS ed. 7	6. DATE OF BIRTH (month, day and seat.) 7. AGE Years Months	Days If LESS than 1 day,		alive on, 19	
H H H H		) hrs. or		d, on the date stated above, atm.	
E P P P P P P P P P P P P P P P P P P P		min.	The CAUSE OF DEAT	rir was as follows:	
	8. OCCUPATION OF DECEASED		1	4-01	
SE THE SE	(a) Trade, profession, or particular kind of work.		0/	allborn	
ADIN ADIN arefull so th	(b) General nature of industry, business, or establishment in			(duration) yrs. mos. ds.	
E E E	which employed (or employer)				
RGIN UNF. be ca erms,	(c) Name of employer		(Secondary)		
- + S	7/10	4 0 1		(duration)yrsmos. ds.	
M./ YYTH iould lain tion	9. BIRTHPLACE (city or town) All State or country)		13. Where was disease contracted if not at place of death?		
n st	10. NAME OF FATHER ()			de death? Date of	
LY, ion H in	Volmer	J. F. Johnson	Was there an autopsy		
nat ATI	2 11. BIRTHPLACE OF FATHER (city of	or town)	What test confirmed di		
PLAINLY nformation DEATH i	(State or Country)	y or town	(Signed)	Dr. Jol Davism. D.	
.=	11. BIRTHPLACE OF FATHER (cit (State or Country))  12. MAIDEN NAME OF MOTHER		$3-17_{19}$	30 (Address 1104	
WRITE m of i ISE OF	2 12. MAIDEN NIME OF MOTHER	Madeen Madeen	<del>/</del>	- cerus errysaa	
WRI item AUSE import	13. BIRTHPLACE OF MOTHER (ct.)	hr town (	*State the DISEASE CAUSES, state (1) M	CAUSING DEATH, or in deaths from VIOLENT IEANS AND NATURE OF INJURY, and (2)	
ite imj	(State or Country)	Mak-	whether ACCIDENTAL	L, SUICIDAL, or HOMICIDAL.	
very ate C	14. Informent Mrs. Volor	on whomoon	19. Place of Burial, C	remation, or Removal Date of Burial	
	(Address)	The all with Alda -	Monnis	Ferry 8/4 3-8 30	
	2 157 2 3	n m	20. Undertaker	Address	
	15. Filed 2 - / / , 150.	ha Mary Sullivan	7/2/201001	olyson Henri Verent	
Zac		registrat	- vival	K	

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PLACE OF BIRTH STATE OF IDAHO County of FranklinD APR 9 1930 DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS. CERTIFICATE OF BIRTH No. Registration District No. 27 State File No. (If born in hospital or institution Prim, Registration District No. 2/19 Local Registrar's No..... give name.) FULL NAME OF CHILD.... of birth (If stillborn, substitute the word "Stillbirth" for name of shild) Number Sex of. Triplet Legiti-Date of in order Child ' or other? birth .... mate? (To be answered only in event of plural births) (Month) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead......Stillborn .... FULL MAIDEN NAME ALL Residence (Usual place of abode) Mink Cruk 1 22 Residence (Usual place of abode) It non-resident, give place and gate, If non-resident, give place and State Color or race. Birthplace //U (City and State or County) (City and State or County) Occupation farmer Occupation Namenty CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Registrar.

modern construction and an income of the Print Besterning Therefore we will be the service of (If ell those, subattuste the wife Stufferse are seem of shills And in their TO MAN .hiseal Colors. CAN'T PLATE (BINK) Linkshames, market of the season objects Acceptable Acceptable then the but now deads. Charles Land december 1 If non-collect, give shop shall Suche which desired in the same of t Colts and State or County occupation in the THE MALIN TO NOTIFICALLY OF DISCUSSION OF ALCOHOLOGY. The state of the s neighbor solbowille on which the exem hivered

ENT RECORD stated EXACTLY, PHYSICIANS d. Exact statement of OCCUPA-	STATE OF IDAM  PLACE OF DEATH  County of Franklin  City of Mink Truk Star  Registration District No  Primary Registration District  (No  (No  (No  (No  The death occurred in a hospital or institution, give its start of the start o	C WELFARE ATISTICS DEATH  2 7 No. 2//9  Local Registrar's No		
cNT Ritated I	(a) Residence. No (Usual place of abode) Length of residence in city or town where death occurred. yrs. mos. ds.	St.  (If nonresident give city or town and State)  How long in U. S., if of foreign birth? yrs. mos. ds.		
INI Fied fied	PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH		
RGIN RESERVED FOR BINDING UNFADING INK—THIS IS A PERMANENT be carefully supplied. AGE should be stated erms, so that it may be properly classified. E n back of certificate.	8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)	16. DATE OF DEATH  // Arch 9 1930  (Month) (Day) (Year)		
	5a. If married, widowed, or divorced HUSBAND of (or) WIFE of	17 HEREBY CERTIFY, That I attended deceased from		
	6. DATE OF BIRTH (month, day and year)  7. AGE  Years  Months  Days  If LESS than 1 day, hrs. or	that I last saw hallest Lives 130 and that death occurred, on the date stated above, at 130 a.m.		
	8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work.	The CAUSE OF DEATH* was as follows:  (duration)  (duration)  (secondary)  (duration)  (duration)  (secondary)  (duration)  (duration)  (secondary)  (duration)  (secondary)  (duration)  (duration)  (secondary)  (duration)  (duration)  (secondary)  (duration)  (secondary)  (duration)  (duration)  (duration)  (secondary)  (duration)  (duration)  (duration)  (duration)  (secondary)  (duration)  (duration)  (duration)  (duration)  (secondary)  (duration)  (duration)  (duration)  (duration)  (duration)  (secondary)  (duration)  (duration)  (duration)  (duration)  (secondary)  (duration)  (duration		
	(b) General nature of industry, , business, or establishment in which employed (or employer)			
MAR WITH Ushould b plain te	9. BIRTHPLACE (city or town) Mink Oruk Jac (State or country)			
PLAINLY, 'nformation EDEATH in See instru	10. NAME OF FATHER Melvin Slamons			
	11. BIRTHPLACE OF FATHER (city or town) (State or Country)  12. MAIDEN NAME OF MOTHER			
	clora uppson			
WRI r item o CAUSE	13. BIRTHPLACE OF MOTHER (city or town) MACAN CAUCAGE (State or Country)	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
Every state C is very	14. Informant Milven Slamous (Address) Mink Cruk, Ida	19. Place of Burial, Cremation, or Removal  Mink Creek, Doa Mar. 10 193		
N. B.— should s	15. Filed Mar // , 1930 Registrar	20. Undertaker Address		
~ ~ ~ ~				

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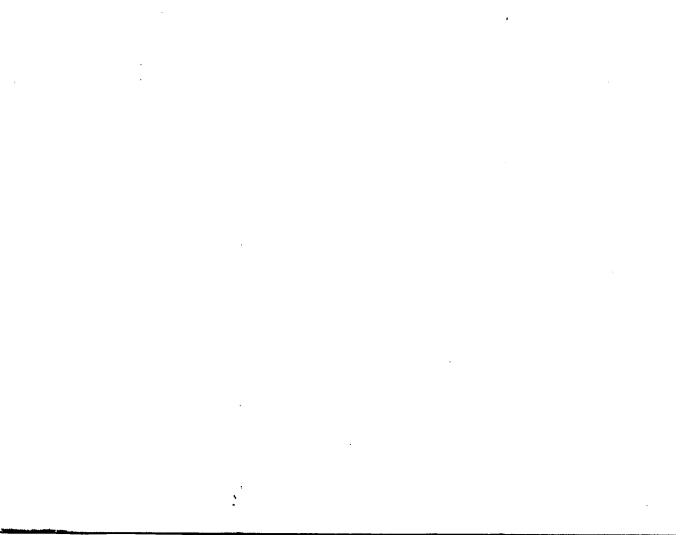
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863.212-003-955 PLACIREGENATED APR 1 1 1930 be made STATE OF IDAHO RECORD County of Dannack DEPARTMENT OF PUBLIC WELFARE City of Pocatello -BUREAU OF VITAL STATISTICS No. St. Anthony St. CERTIFICATE OF BIRTH PERMANENT E RETURN m Registration District No. 28 State File No. Los a ital order of birth stated. (If born in hospital or institution Prim. Registration District No. 2/6/Local Registrar's No. 9.686 give name.) FULL NAME OF CHILD (If stiffborn, substitute the word "Stillbirth" for name of child) Twin Sex of Number Child Female Triplet Legitiin order Date of or other? of birth yes birth 2 (To be answered only in event of plural births) mate? What prophylactic was used to prevent Ophthalmia Neonatorum? (Month) (Day) (Year) Born alive but now dead......Stillborn ..... birth FULL MOTHER MAIDEN NAME LEGL Residence (Usual place of abode) £16 71 th Residence (Usual place of abode) 816 Yarth It non-resident, give place and State\_\_\_\_\_ If non-resident, give place and State\_\_\_\_\_ (City and State or County) (City and State or County) Occupation Zhouse wi more CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was \ Stillborn case of on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE

property that I had seen to decount Obsestable Reference and the last combined to Caption 1-4 to and The server Hir thallpon Motten month MOST SEE OF A PRINTER PRINTERS OF MISTERS Millamble in their latteness the hier of the latter of the (Menathe) ate, planti white the return it athliboru the section resident was the place APIM TOUTE OUT TO SOME ONE ASSESSMENTS

ANS PA-	STATE OF IDAE	THE TABLE		
<u> </u>	PLACE OF DEATH BUREAU OF VITAL ST	DO NOT WINTE IN THIS SPACE		
F RECORD ed EXACTLY, PHYSICIAN; Exact statement of OCCUPA	County of Bannock CERTIFICATE OF			
PH	City of	28		
K, ent	Primary Registration District	No2164 Local Registrar's No. 57762		
O F E	(No. St Anthony Hos  (If death occurred in a hospital or institution, give its i	pital (a)		
RECORD EXACT sact state	1	name instead of street and number.)		
r e e	2. FULL NAME Infant Holcomb			
z t	(a) Residence. No. 816 North 12th St. (Usual place of abode) Length of residence in city or town where death occurred. yrs. mos. ds.	St.  (If nonresident give city or town and State)  How long in U. S., if of foreign birth? yrs. mos. ds.		
INE fied	PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH		
MA   be   besif	8. SEX 4. COLOR OR RACE 5. Single Married, Widowed.	16. DATE OF DEATH		
BINDING IS A PERMANENT AGE should be state properly classified. E	Female White or Divorced (write the word) Single	February 12th, 19 30 (Month) (Day) (Year)		
	5a. If married, widowed, or divorced HUSBAND of	17. I HEREBY CERTIFY, That I attended deceased from		
BINI IS A AGE prope	(or) WIFE of			
FOR THIS ed. ∠	6. DATE OF BIRTH (month, day and year) Feb 12, 1930.	that I last saw h alive on, 19		
I•= 65∑	7. AGE Years Months Days If LESS than 1 day,	and that death occurred, on the date stated above, at		
RVED FOR INK—THE SUPPLIED IT MAY THE	Stillborne min.	The CAUSE OF DEATH* was as follows:		
<b>—</b> — — —	8. OCCUPATION OF DECEASED			
RESERVED DING INK—refully supples that it may of certification	(a) Trade, profession, or Infant particular kind of work	Breach dilinery -		
	(b) General nature of industry, business, or establishment in	(direction)		
GIN NFA] e car ms, s	which employed (or employer)	CONTRIBUTORY Slianfulatio Cord -		
	(c) Name of employer	(Secondary)		
WITH WITH should plain ction	9. BIRTHPLACE (city or town) Pogatello_	(duration)yrsmosds.		
WITI WITI shoul plair iction	(State or country) Idaho	18. Where was disease contracted if not at place of death?		
NLY, ation of FH in	10. NAME OF FATHER  W. C. Holgomb	Did an operation precede death? Date of		
E and in	the promiser and on promiser and the state of the state o	Was there an autopsy?		
WRITE PLAINLY item of information CAUSE OF DEATH inportant. See insti	11. BIRTHPLACE OF FATHER (city or town) The Attending (State or Country)  12. MAIDEN NAME OF MOTHER Took Poorse	What test confirmed diagnosis?   (Signed)   (Signed)   M. D.		
e in Fr	12. MAIDEN NAME OF MOTHER	(Signed) Faculty, M. D.		
	neau reese	(Address)		
WR USE	18. BIRTHPLACE OF MOTHER (city or town) Boldburg (State or Country)	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
CAT	(State of Country) Idaho	whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
	14. Informant W. C. Holcomb	19. Place of Burial, Cremation, or Removal Date of Burial		
Ever state is ver	(Address) 816 No 12th, Ave	Mountain View Cemetery Feb 13 30		
( <del></del>	15. Filed 2/13, 180, Many	Mountain View Cemetery Feb 13 30 20. Undertaker Address		
N. B.	Filed // S , 190 Registrar	Hall Mortuary		
W.C				

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Do not accept a certificate of death signed only by a

midwife.

RECEIVED APR 4 1930 PLACE OF BIRTH STATE OF IDAHO RECORD DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS City of CERTIFICATE OF BIRTH S A PERMANENT TE RETURN must birth stated. Registration District No..... State File No..... (If born in hospital or institution Prim. Registration District No. 20/3 Local Registrar's No. JO give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Sex of Date of Legiti-Triplet in order Child And or other? of birth mate? UL birth (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth. (a) Born slive and now living Born alive but now dead. Stillborn a.5 FATHÉR MOTHE birth each, FULL MAIDEN reading at b Residence (Usual place of abode)... Residence (Usual place of abode) If nonresident, give place and State If nonresident, give place and State Color or race Age at last Birthday Color or race Age at last Birthday\_ (Years) Birthplace Birthplace (City and State or Country) (City and State or Country) Occupation : Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* Down elive I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. 6 (Signature) Case \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth. Registrar.

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<b>₹</b> 5		DEPARTMENT OF PUBLIC		DO NOT WRITE IN THIS SPACE		
PHYSICIA it of OCCUP		PLACE OF DEATH  BUREAU OF VITAL ST  CERTIFICATE OF	17 1 69 4			
HY.	Co	unty of Williams	1 G	State File No.		
Y, Pl	Ci	ty of Registration District No	Local Registrants No. /			
r RECORD ed EXACTLY, I Exact statement	2.	(If death for furred in a hospital or institution, give its  FULL NAME	<u>e</u>	) number.)		
ENT state	L	(Usual place of abode)	(If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.			
ERMANENT uld be stat classified.		PERSONAL AND STATISTICAL PARTICULARS	MEDIC	AL CERTIFICATE OF DEATH		
PERMANENT Should be state tly classified. E	8.	SEX 4. COLOR OF RACE 5. Single, Married, Widowed, or Divorced (write the good)	16. DATE OF DEAT	Mar 2232		
Selbo Para		a. If married, widowed, or divorced		(Month) (Day) (Year)		
SISAP AGE sho properly	HUSBAND of (or) WIFE of		17. I HEREBY CERTIFY, That I attended deceased from			
ا ، ` 20 د.	6. DATE OF BIRTH (month, day and year) 7. AGE Years   Months Days   If, LESS, than 1 day,		11			
ed.			11	alive on, 19, 19		
K—Ti pplied may cate.		that min.	The CAUSE OF DEA	, , , , , , , , , , , , , , , , , , , ,		
INK—TE Supplied. it may   tificate.	8.	OCCUPATION OF DECEASED	ashwale	in Monatoum		
ヨー しせきし	٠.	(a) Trade, profession, or				
ADING arefully so tha		particular kind of work				
FADING carefully so the ack of co		(b) General nature of industry, business, or establishment in	(duration)yrsmosds.			
Pas Sas		which employed (or employer)				
T UNI	(c) Name of employer		(Secondary)			
WITH Should plain iction	9. BIRTHPLACE (city or town) down		(duration)yrsmosds.  18. Where was disease contracted			
	(State or country)		if not at place of death?			
NLY, ttion (TH in instru	10. NAME OF FATHER		Did an operation prece	de death?Date of		
	70		Was there an autopsy	/ /		
LAI orm See	ENTS	11. BIRTHPLACE OF FATHER (city or town) (State or Country)	What test confirmed di	- 9/ // //		
TE P of inf OF I	PARE	Mondana	(Signed) FRAN	(Address)		
WRITE m of i JSE OF	A.	12. MAIDEN NAME OF MOTHER William		(Address)		
ire AT		13. BIRTHPLACE OF MOTHER (city or town) Canada	*State the DISEASE CAUSES, state (1) h whether ACCIDENTAL	CAUSING DEATH, or in deaths from VIOLENT MEANS AND NATURE OF INJURY, and (2) L. SUICIDAL, or HOMICIDAL.		
Every state C	14. Informant Vieter P Hall		19. Place of Burial, C			
-Ever state is ver		(Address) Ruhest I doho P. 3.	Rubert Ge	metry Mar 23 10 30		
N. B should TION	15	Filed 6 - 10 , 1930 Elt Elmore	26. Whdertaker	Address, A. A. A.		
241		Registrar	1 11.0%	manger   when I do		

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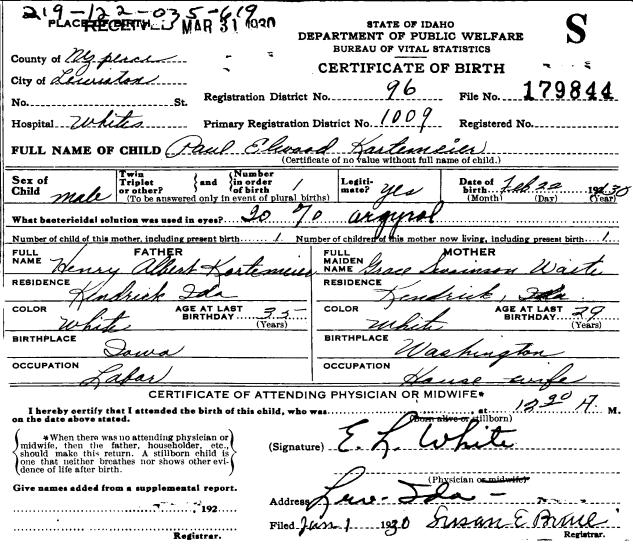
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ECORD EXACTLY, PHYSICIANS ct statement of OCCUPA-	PLACE OF DEATH  County of City of City of County of County of County of City o	DO NOT WRITE IN THIS SPACE ATISTICS DEATH State File No
NT RECated EX	2. FULL NAME. Day Konte succes  (a) Residence. No.  (Usual place of abode)  Length of residence in city or town where death occurred. yrs. mos. ds.	
DING A PERM should lerly class	PERSONAL AND STATISTICAL PARTICULARS  8. SEX  4. COLOR OR RACE  5. Single, Married, Widowed, or Divorced (write the word)  5a. If married, widowed, or divorced HUSBAND of	16. DATE OF DEATH  (Month)  (Day)  (Year)  17. I HEREBY CERTIFY, That I attended deceased from
FOR THIS lied.	6. DATE OF BIRTH (month, day and year) feb 22-1930  7. AGE Years Months Days If LESS than 1 day, hrs. or min.	that I last saw h alive on , 19 and that death occurred, on the date stated above, at
RESER ADING I refully so that k of cer	8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work  (b) General nature of industry, business, or establishment in which employed (or employer)	(duration) yrs. mos. dis.
MARGIN, WITH UNFA is should be can in plain terms, ruction on back	9. BIRTHPLACE (city or town) (State or country)	CONTRIBUTORY (Secondary)  (duration)  18. Where was disease contracted if not at place of death?  Did an operation precede death?  Date of
E PLAINLY information F DEATH int. See inst	11. BIRTHPLACE OF FATHER (city or town) (State or Country)  12. MAIDEN NAME OF MOTHER	Was there an autopsy?  What test confirmed diagnosis?  (Signed)  2-24  1930 (Address)
WRITH WRITH Y item of CAUSE O	18. BIRTHPLACE OF MOTHER (city or town) (State or Country)  14.	"State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  19. Place of Burial, Cremation, or Remodal Date of Burial
N. B.—Every should state (TION is very	Informant (Address)  (Address)  15. Filed M. 1 , 1930 Man & Bruce Registrar	Lewister Merting Lewister

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## RECEIVED MAY 3 1090

DIVISION OF VITAL STATISTICS DEPARTMENT OF COMMERCE BUREAU OF VITAL STATISTICS

C.K. MACEY SPECIAL AGENT

Boise, Idaho

APR 21 1030

## 179975

Mrs. R.G. Beeson Kimberly BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

- Doar Madam:

ILAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

| PLACE OF<br>BIRTH**                   | Kimberly                                                      | DATE OF BIRTH   | Feb. 14, | 1930        | SEX OF CHILD               | Male         |
|---------------------------------------|---------------------------------------------------------------|-----------------|----------|-------------|----------------------------|--------------|
| 2. Number<br>3. Born al               | of children born to<br>born alive and now<br>ive but now dead | living <u>/</u> | , includ | ing presen  | t birth/                   |              |
| 4. Number                             | of children stillbo                                           |                 |          |             |                            |              |
|                                       | (P                                                            | lease write     | plainly) | •           |                            |              |
|                                       | tion with reference  FATHER  (Full name)                      | _               | (asid)   | _           | ion with religion of the R |              |
| <del>.</del>                          | (Residence)                                                   |                 |          |             | Residence)                 |              |
|                                       | t birthday 2 /                                                |                 | Age a    | at last bir | thday <                    | <u>کا ۔ </u> |
| Earli                                 | (Birthplace)                                                  |                 | · · ·    | 16a 10x     | Sirthplace)                | 7.2          |
| · · · · · · · · · · · · · · · · · · · | (Occupation)                                                  |                 |          |             |                            |              |

C.K. Modey / Special Agent, Bureau of the Census.

Sincerely Yours,

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| 100 X                                       | , ,:                                                                                                                                                                      | RECE STATE OF IDA                                                                       | TTO 6                                                                                             |  |  |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--|--|
| PAN -                                       |                                                                                                                                                                           | DEPARTMENT OF PUBLI                                                                     | C WELFARE DO NOT WRITE IN THIS SPACE                                                              |  |  |
|                                             | PLACE OF DEATH  County of Washington  City of Wesser  City of Primary Registration District  City of Primary Registration District                                        |                                                                                         | ATISTICS 2 2 AND WATE IN THIS STATE                                                               |  |  |
| PHYSICIAL<br>of OCCUP                       |                                                                                                                                                                           |                                                                                         | DEATH State File No                                                                               |  |  |
| *                                           |                                                                                                                                                                           |                                                                                         | Local Registrar's No. 13                                                                          |  |  |
| CLY<br>FLY                                  |                                                                                                                                                                           | (No                                                                                     | NoX.                                                                                              |  |  |
| ECORD<br>EXACTLY,<br>ict statemer           |                                                                                                                                                                           | (If death occurred in a hospital or institution, give its                               | name instead of street and number.)                                                               |  |  |
| RECORD<br>EXACT<br>Kact state               | 2.                                                                                                                                                                        | FULL NAME Joseph alous the                                                              | is by                                                                                             |  |  |
| 70,23                                       | _                                                                                                                                                                         | (a) Residence. No. Wees & Ca (Usual place of abode)                                     | St. (If nonresident give city or town and State)                                                  |  |  |
| Sta Sta                                     | L                                                                                                                                                                         | ength of residence in city or town where death occurred. yrs. mos. ds.                  | now long in U. S., it of foreign birth? yrs. mos. ds.                                             |  |  |
| NG PERMANENT nould be state r classified. F | -                                                                                                                                                                         | PERSONAL AND STATISTICAL PARTICULARS  SEX 4. COLOR OR RACE 5. Single, Married, Widowed, | MEDICAL CERTIFICATE OF DEATH                                                                      |  |  |
|                                             | ٥.                                                                                                                                                                        | or Divorced (write the word)                                                            | Flb- 24 1930                                                                                      |  |  |
| DING<br>A PE<br>shou<br>erly cl             | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                                                                              |                                                                                         | (Lonth) (Des) (Year)                                                                              |  |  |
| IS I    |                                                                                                                                                                           |                                                                                         | 17 I HEREBY CERTIFY, That I attended deceased from                                                |  |  |
| H SH H                                      | 6. DATE OF BIRTH (month, day and year) Stillborn                                                                                                                          |                                                                                         | that I last saw he alive on 19                                                                    |  |  |
| lied.                                       | 7.                                                                                                                                                                        | AGE Years Months Days If LESS than 1 day, hrs. or                                       | and that death occurred, on the date stated above, atm.                                           |  |  |
| L DD L                                      | 8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer) |                                                                                         | The GAUSE OF DEATH* was as follows:  Cause (duration) yrs, mos, ds,                               |  |  |
| G II                                        |                                                                                                                                                                           |                                                                                         |                                                                                                   |  |  |
| of E                                        |                                                                                                                                                                           |                                                                                         |                                                                                                   |  |  |
| EAI<br>Car<br>sck 8                         |                                                                                                                                                                           |                                                                                         |                                                                                                   |  |  |
| E P C R                                     | <br> -                                                                                                                                                                    | (c) Name of employer                                                                    | CONTRIBUTORY (Secondary)                                                                          |  |  |
| MA<br>ITTH<br>ould<br>lain<br>ion o         | 9. BIRTHPLACE (city or town) Wesser                                                                                                                                       |                                                                                         | (duration) yrs. mos. ds.                                                                          |  |  |
| WI she uction                               | (State or country)                                                                                                                                                        |                                                                                         | 18. Where was disease contracted if not at place of death?                                        |  |  |
| LY,<br>tion<br>H in                         | 10. NAME OF FATHER R. Shirls                                                                                                                                              |                                                                                         | Did an operation precede death? Date of                                                           |  |  |
| PLAINLY<br>nformation<br>DEATH i            | 2                                                                                                                                                                         | 11. BIRTHPLACE OF FATHER (city or town)                                                 | Was there an autopsy?  What test confirmed diagnosis  (Signed) / Chronic M. D.                    |  |  |
| PL DI S                                     | RENTS                                                                                                                                                                     | Jowa                                                                                    |                                                                                                   |  |  |
| WRITE<br>em of<br>ISE OF<br>portant         | PAR                                                                                                                                                                       | 12. MAIDEN NAME OF MOTHER alderson                                                      | 4-47, 1930 (Address) Whan Ide                                                                     |  |  |
| WRI<br>item<br>AUSE<br>import               |                                                                                                                                                                           | 18. BIRTHPLACE OF MOTHER (city or town)                                                 | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT                                       |  |  |
| <i>→</i> <                                  |                                                                                                                                                                           | Washing ton                                                                             | CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |  |  |
| Soco                                        | Informant Informant                                                                                                                                                       |                                                                                         | 19. Place of Burial, Cremation, or Removal  Date of Burial  7 - 2 5 19 3                          |  |  |
|                                             |                                                                                                                                                                           | (Address) Cleser Fac 1770 2                                                             | 20. Undertaker Address                                                                            |  |  |
| For Boal                                    | 15.                                                                                                                                                                       | Filed Much 14, 10 30 N. 17 Nauce M. Registrar                                           | L'o northan Weentha                                                                               |  |  |
| 400                                         |                                                                                                                                                                           |                                                                                         |                                                                                                   |  |  |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the firstline will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia: Bronchopneumonia ("Pneumonia." unqualified, is indefinite); Tuberculosis of lungs, use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide: Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

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STATE OF IDAHO RECORD be made fo DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH PERMANENT I RETURN must b th stated. Registration District No..... State File No.... (If born in hospital or institution Prim, Registration District No. 2/6/ Local Registrar's No. 760 give name.) FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Date of Sex of Legiti-Triplet in order birth & Child or other? of hirth (To be answered only in event of plural births) (Month) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth... (a) Born alive and now living... Born alive but now dead. Stillborn BATHER FULL! MAIDEN Residence (Usual place of abode). Residence ((Usual place of abode) If nonresident, give place and State. If nonresident, give place and State... Age at last Binthday Birthplace Birthplace. (City and State or Sountry) Country) City and State of Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* more I hereby certify that I attended the birth of this child, who was \ Stillborn on the date above stated. (Signature) \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth.

| 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Dane.                   | TOTAL TRANS                         | <b>1</b>                  |                                           | Mary 1                              |
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| The Control of the Control                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | to sman tel "elektring" | . dissettute the west               | module is                 |                                           |                                     |
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| AN SERVICE SER | RECEIVED MAY 5 1930 EPARTMENT OF PUBLIC PLACE OF DEATH AS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | DO NOT WINTED                                                                                                     | IN THIS SPACE      |  |
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| E III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | name instead of street and number.)                                                                               |                    |  |
| RECORD<br>EXACTLY<br>cact statemen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (If death occurred in a hospital or institution, give its                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | name instead of street and number.)                                                                               | 100 A              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. FULL NAME MULTINA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                   |                    |  |
| ated<br>Ey                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (a) Residence. No. (Usual place of abode)  Length of residence in city or town where death occurred. yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | St.  (If nonresident give city of How long in U. S., if of foreign birth?                                         |                    |  |
| ING<br>PERMANENT<br>should be state<br>Iy classified. E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF D                                                                                          | EATH               |  |
| RM/<br>d b<br>assi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 3. SEX 4. COLOR OB BACE 5. Single, Married, Widowed, or Divorces (write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 16. DATE OF DEATH                                                                                                 | 0- 2               |  |
| NG<br>PEI<br>Col                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Male White Dingle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (Month) (De                                                                                                       | y) (Year)          |  |
| ADI<br>Peri                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5a. If married, widowed, or divorced HUSBAND of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 17. I HEREBY CERTIFY, That I attended dec                                                                         |                    |  |
| BINI<br>IS AGE<br>prope                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | At Buston 19 to Hell                                                                                              | - 8 , 1030         |  |
| FOR THIS ed. A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. DATE OF BIRTH (month, day and year)  7. AGE Years Months Days If LESS_than 1 day,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | that I last saw h demonstree on                                                                                   | 12-2-8,1030        |  |
| D For Tiled                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | hrs. or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | and that death occurred, on the date stated above The CAUSE OF DEATH* was as follows:                             | , at , com, m.     |  |
| RVED<br>INK—<br>supplications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 8. OCCUPATION OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Injury during                                                                                                     | birth              |  |
| # + H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (a) Trade, profession, or particular kind of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   |                    |  |
| RESE<br>DING<br>refully<br>so tha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (h). General nature of industry.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   |                    |  |
| RGIN<br>UNFA<br>be car<br>erms, s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | business, or establishment in which employed (or employer)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | contributory Disposition in outlit of                                                                             |                    |  |
| ARG<br>UN<br>  be<br>term<br>on b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (c) Name of employer Mone                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                   |                    |  |
| 7 H T _ T                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 9. BIRTHPLACE (city or town) My Campra                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (duration) y                                                                                                      | rs ds.             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 18. Where was disease contracted if not at place of death?                                                        |                    |  |
| LY,<br>ion<br>I in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 10. NAME OF FATHER ( ) Server Hollman                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Did an operation precede death?                                                                                   | of                 |  |
| PLAINLY<br>nformation<br>DEATH i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. BIRTHPLACE OF FATHER (city or town Adving                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Was there an autopsy? Who                                                                                         |                    |  |
| PLA<br>DE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (Signed) Sigh                                                                                                     | , M. D.            |  |
| of ir<br>OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 12. MAIDEN NAME OF MOTHER Winised Thomaso                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1830 (Address) Las                                                                                                | a Hot apringe      |  |
| WRITE<br>y item of in<br>CAUSE OF<br>y important.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 13. BIRTHPLACE OF MOTHER (19thy or town) Down hay (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | *State the DISEASE CAUSING DEATH, or in CAUSES, state (1) MEANS AND NATURE whether ACCIDENTAL, SUICIDAL, or HOMIC | OF INJURY, and (2) |  |
| Ever<br>tate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 14. Informant & Bich MD. copy from Birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 19. Place of Burial, Cremation, or Removal                                                                        | Date of Burial     |  |
| V. B.—]<br>hould so                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 15. Filed Grand 1930. Mus 9 9 February                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 20. Undertaker                                                                                                    | Address            |  |
| ~ 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | the state of the s |                                                                                                                   |                    |  |

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine. etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH-Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemie cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia: Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "In "ition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide: Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS-Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

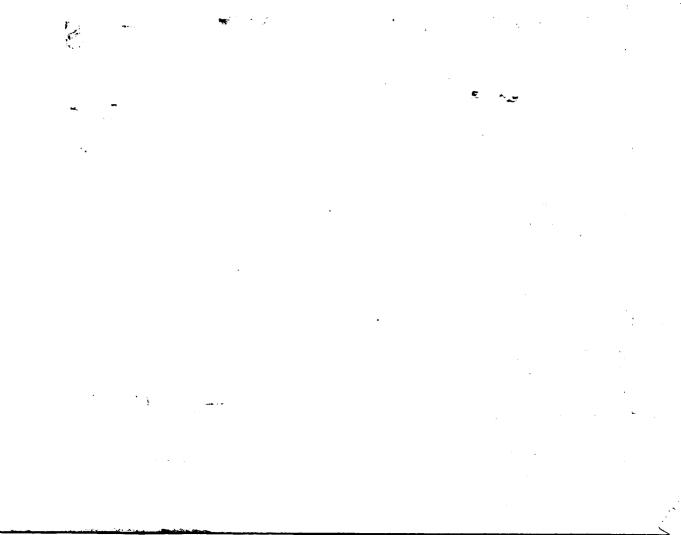
Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

STATE OF IDAHO RECORD be made for PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH PERMANENT I RETURN must b th stated. Registration District No. State File No..... Prim. Registration District No. 194 Local Registrar's No. (If born in hospital or institution give name.) FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of Number Date of Sex of Legiti-7 in order birth Child \ or other? mate? (To be answered only in event of plural births) (Mont) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth... (a) Born alive and now living. Born alive but now dead... Stillborn FATHER MOTHER FULL FIII. NAMEC UNFADING one child at bi number of ea Residence (Usual place of abode) Residence (Usual place of abode)... If nonresident, give place and State Age at last Birthday.... Age at last Birthday Birthplace Birthplace (City and State or Country) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE I hereby certify that I attended the birth of this child, who was PLAINLY on the date above stated. (Signature) \*Where there was no attending physician WRITE or midwife, then the father, householder, etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth. Registrar.



| 4S<br>A-                                                                                   | STATE OF IDA                                                                                   |                                                                                                                   |  |  |
|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|--|--|
| PHYSICIAN                                                                                  | RECEIVED MAY 7 1930EPARTMENT OF PUBLI                                                          | = 0 = 10 = 11 = 111 = 1110 0 = 1101                                                                               |  |  |
| SIC                                                                                        | PLACE OF DEATH  BUREAU OF VITAL ST  CERTIFICATE OF                                             | 77 (* 1) 4 22 1                                                                                                   |  |  |
| ##<br>0                                                                                    | County of Registration District No                                                             | State File No.                                                                                                    |  |  |
| =                                                                                          | City of District No                                                                            | Local Registrar's No. 49                                                                                          |  |  |
| LY,                                                                                        |                                                                                                | ,                                                                                                                 |  |  |
| ORD<br>ACTLY,<br>statement                                                                 | (If death occurred in a hospital or institution, give its                                      | name instead of street and number.)                                                                               |  |  |
| ECORD<br>EXACTLY,<br>act statemer                                                          | 2. FULL NAME Stillborn Min                                                                     | -docto                                                                                                            |  |  |
| . R. 3<br>3xa                                                                              | (a) Residence. No. Blackfood R. 7. J. #                                                        | 1 St.                                                                                                             |  |  |
| VENT REC<br>stated EX<br>ed. Exact                                                         | (Usual place of abode) Length of residence in city or town where death occurred. yrs. mos. ds. | (If nonresident give city or town and State)  How long in U. S., if of foreign birth? yrs. mos. ds.               |  |  |
| DING A PERMANENT RECORD should be stated EXACT ferly classified. Exact state               | PERSONAL AND STATISTICAL PARTICULARS                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                      |  |  |
| RM.<br>Id I                                                                                | 3. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)              | 16. DATE OF DEATH april                                                                                           |  |  |
| ING PERM should rly clas                                                                   | Remal White                                                                                    | (Month) (Day) (Year)                                                                                              |  |  |
|                                                                                            | 5a. If married, widowed, or divorced HUSBAND of                                                | 17. I HEREBY CERTIFY, That I attended deceased from                                                               |  |  |
| BIN<br>IS AGE                                                                              | (or) WIFE of                                                                                   | if // , 1930, to /// , 193                                                                                        |  |  |
| FOR THIS led. Ity be 1                                                                     | 6. DATE OF BIRTH (month, day and year)                                                         | that I last saw her alive on Staffford 19                                                                         |  |  |
|                                                                                            | 7. AGE Years Months Days If LESS than 1 day, hrs. or                                           | and that death occurred, on the date stated above, at                                                             |  |  |
| RESERVED FOR INK—TI SETULLY SUPPLIED TO THAT IT MAY OF CERTIFICATE.                        | 8. OCCUPATION OF DECEASED                                                                      | The CAUSE OF DEATH* was as follows:                                                                               |  |  |
| SER IG III s hat i                                                                         |                                                                                                | Placenta Previa                                                                                                   |  |  |
| RGIN RESERVE<br>UNFADING INK<br>be carefully supjerms, so that it in<br>a back of certific | (a) Trade, profession, or particular kind of work                                              | Complete Central                                                                                                  |  |  |
|                                                                                            | (b) General nature of industry, business, or establishment in which employed (or employer)     | (duration)yrsmosds.                                                                                               |  |  |
| RGIN<br>UNFA<br>be cal<br>erms,<br>n back                                                  | (c) Name of employer                                                                           | CONTRIBUTORY (Secondary)                                                                                          |  |  |
| <b>~</b>                                                                                   | ne let                                                                                         | (duration)yrsmosds.                                                                                               |  |  |
| MANTH<br>WITH<br>should<br>plain<br>iction                                                 | 9. BIRTHPLACE (city or town)                                                                   | 18. Where was disease contracted if not at place of death?                                                        |  |  |
|                                                                                            | 10. NAME OF FATHER 9 10 7                                                                      | Did an operation precede death? Date of                                                                           |  |  |
| PLAINLY,<br>nformation<br>DEATH in<br>See instr                                            | Les V murdait                                                                                  | Was there an autopsy?                                                                                             |  |  |
| AI EA                                                                                      | 11. BIRTHPLACE OF FATHER (city or town) (State or Country)                                     | What test confirmed diagnosis?                                                                                    |  |  |
|                                                                                            | (State or Country)  12. MAIDEN NAME OF MOTHER                                                  | (Signed) , M. D.                                                                                                  |  |  |
| WRITE  <br>em of in<br>JSE OF                                                              | 12. MAIDEN NAME OF MOTHER Francis Lance                                                        | 1930 (Address) Deach of and                                                                                       |  |  |
| WRI<br>item (AUSE                                                                          | 18. BIRTHPLACE OF MOTHER (city or town) Wilson (State or Country)                              | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) |  |  |
| 7)                                                                                         | Wah                                                                                            | whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                       |  |  |
| -Every<br>state (<br>s very                                                                | 14. Informant Les Dundouff                                                                     | 19. Place of Burial, Cremation, or Removal Date of Burial                                                         |  |  |
| is sta                                                                                     | (Address) Blackbook NP#2                                                                       | Thomas Revuest your 1850                                                                                          |  |  |
| A EN                                                                                       | 16. Filed april 1950 mo dealus En atu                                                          | 20. Undertaker Address                                                                                            |  |  |
| z, g, T                                                                                    | Registrar                                                                                      | I go plet stulfor                                                                                                 |  |  |
|                                                                                            | V                                                                                              | <b>4</b>                                                                                                          |  |  |

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struck by railway train-accident; Revolver wound of

head-homicide; Poisoned by carbolic acid-probably sui-

cide. The nature of the injury, as fractured skull, and con-

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PLACE OF BIRTH - STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Nα. State File No... Registration District No... (If born in hospital or institution Prim. Registration District No. / 1 Local Registrar's No. / 0/ give name.) Stillhom FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number Date of -Legiti-Sex of Triplet and in order birth ///a Child. or other? mate? (To be answered only in event of plural births) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? FIII.L. MAIDEN NAME -Residence (Usual place of abode) Residence (Usual place of abode) ... It non-resident, give place and State If non-resident, give place and State ... Color or race Age at last Birthday Birthplace and State or County) (City and State or County) Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE® I hereby certify that I attended the birth of this child, who was | Stillbean on the date above stated. (Signature) \*Where there was no attending physician? or midwife, then the father, householder, Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Registrar.

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William St. and Milliam Stew on Albitration of the Milliam St. March 1997.

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| RECORD  EXACTLY, PHYSICIANS xact statement of OCCUPA-                                                                                                                                                                                                                              | PLACE OF DEATH  PLACE OF DEATH  County of City of Primary Registration District No.  (If death occurred in a hospital or institution, give its case)  (a) Residence. No.                                                                          | DEATH  State File No                                                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MARGIN RESERVED FOR BINDING WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT litem of information should be carefully supplied. AGE should be stated AUSE OF DEATH in plain terms, so that it may be properly classified. Eximportant. See instruction on back of certificate. | Length of residence in city or town where death occurred. yrs. mos. ds.  PERSONAL AND STATISTICAL PARTICULARS  3. SEX  4. COLOR OR RACE 5. Single Married, Widowed, or Divorsed (write-the word)  5a. If married, widowed, or divorced HUSBAND of | (If nonresident give city or town and State)  How long in U. S., if of foreign birth? yrs. mos. ds.  MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  (Month) (Day) (Year)  17. I HEREBY, CERTIFY, That I attended deceased from |
|                                                                                                                                                                                                                                                                                    | (or) WIFE of  6. DATE OF BIRTH (month, day and year)  7. AGE Years Months Days LLESS than 1 day, hrs. or  8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work                                                            | The CAUSE OF DEATH* was as follows:                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                    | (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer  9. BIRTHPLACE (city or town) Jallo H. (State or country)                                                                        | (duration) yrs, mos. ds.  CONTRIBUTORY (Secondary)  (duration) yrs, mos. ds.  18. Where was disease contracted if not at place of death?                                                                                         |
|                                                                                                                                                                                                                                                                                    | 10. NAME OF FATHER  11. BIRTHPLACE OF EATHER (city or town)  (State or Country)  12. MAIDEN NAME OF MOTHER (1)                                                                                                                                    | Did an operation precede death Date of Was there an autopsy?  What test confirmed diagnosis?  (Signed) , M. D, 19 (Address)                                                                                                      |
| WRI<br>N. B.—Every item of<br>should state CAUSE<br>TION is very import.                                                                                                                                                                                                           | 13. BIRTHPLACE OF MOTHER (city or town)  14. Informant (Address)  15. Filed  16. Registrar                                                                                                                                                        | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) See of Burial, Cremation, or Removal  19. Place of Burial, Cremation, or Removal  20. Undertaker  Address      |

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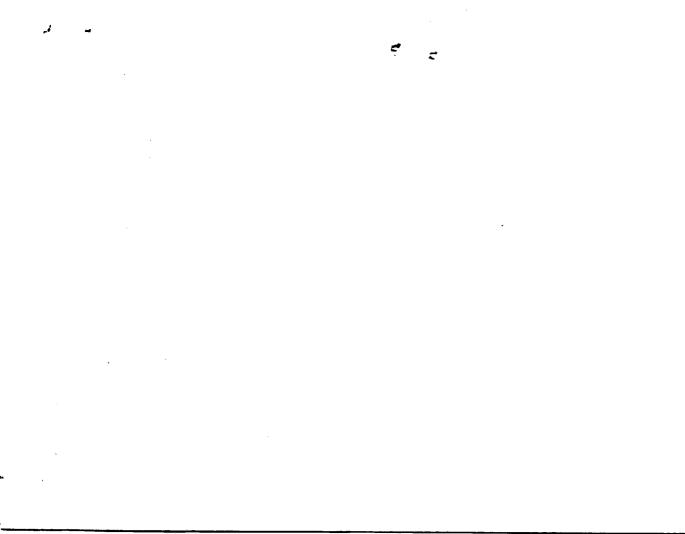
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| »· II                                             | RECEIVED MAY 1 0 1930 STATE OF I                                                                                                                                                                                                                | DO NOT WRITE IN THIS SPACE                                                                                                                                                                     |  |  |  |  |
|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| *                                                 | DEPARTMENT OF PU<br>BUREAU OF VITAL<br>PLACE OF DEATH                                                                                                                                                                                           | BLIC WELFARE                                                                                                                                                                                   |  |  |  |  |
| 5                                                 | County of Carrier County                                                                                                                                                                                                                        |                                                                                                                                                                                                |  |  |  |  |
| PHYSICIAN                                         | Registration District No                                                                                                                                                                                                                        | 2                                                                                                                                                                                              |  |  |  |  |
|                                                   | City of Primary Registration Distri                                                                                                                                                                                                             |                                                                                                                                                                                                |  |  |  |  |
| •                                                 |                                                                                                                                                                                                                                                 | , , , , , , , , , , , , , , , , , , , ,                                                                                                                                                        |  |  |  |  |
| ACTLY<br>iffied.<br>back.                         | (If death occurred in a hospital or institution, a  2. FULL NAME Cubrey Caul Beal                                                                                                                                                               | rive its name instead of street and number.)                                                                                                                                                   |  |  |  |  |
| ed EXA ily classi ions en l                       | (a) Residence. No. State State State State (If nonresident give city or town and State.)  (Usual place of abode.)  Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. |                                                                                                                                                                                                |  |  |  |  |
| RD,<br>be stated<br>e properly<br>instruction     | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                            | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                   |  |  |  |  |
| _ 8=°                                             | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed or Divorced (write the word.)                                                                                                                                                               | 16. DATE OF DEATH  (Month)  (Day)  (Year)                                                                                                                                                      |  |  |  |  |
| BINDING FENT REC GE should st it may rtant. So    | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                                                                                                                                                    | 17. I HEREBY CERTIFY, That I attended deceased from 19. 3.4 to 19                                                                                                                              |  |  |  |  |
|                                                   | 6. DATE OF BIRTH (month, day and year) Quil 29-193                                                                                                                                                                                              | that I last saw h alive on 4 100                                                                                                                                                               |  |  |  |  |
| FE ST ST                                          | 7. AGE Years Months Days If LESS than 1 day, hrs, or                                                                                                                                                                                            |                                                                                                                                                                                                |  |  |  |  |
| SERVEI 13 A P 14 seepplicate term NA term NA term | 8. OCCUPATION OF DECEASED  (a) Trade, profession. or particular kind of work.                                                                                                                                                                   | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH* was follows: |  |  |  |  |
| N BL                                              | (b) General nature of industry, business, or establishment in which employed (or employer)                                                                                                                                                      |                                                                                                                                                                                                |  |  |  |  |
| IARGI<br>INK<br>I be e                            | (e) Name of employer                                                                                                                                                                                                                            |                                                                                                                                                                                                |  |  |  |  |
|                                                   | 9. BIRTHPLACE (city or town) (State or country)                                                                                                                                                                                                 |                                                                                                                                                                                                |  |  |  |  |
| NFADI<br>ation s<br>USE O                         | 10. NAME OF FATHER C. P. Beckey.                                                                                                                                                                                                                | (Secondary) (duration) yrs. mos. ds.                                                                                                                                                           |  |  |  |  |
| TTH U Informate CA ste CA ste CA sta              | 11. BIRTHPLACE OF FATHER (city or town)                                                                                                                                                                                                         | Did an operation precede death?  Did an autopsy?  What test confirmed diagnosis?                                                                                                               |  |  |  |  |
| C. WI                                             | 12. MAIDEN NAME OF MOTHER TO ST. Base                                                                                                                                                                                                           |                                                                                                                                                                                                |  |  |  |  |
| AINLY<br>ry item<br>shou                          | 18. BIRTHPLACE OF MOTHER (city or town)                                                                                                                                                                                                         | (Signed) M. D. (Address) Lawfe Odok                                                                                                                                                            |  |  |  |  |
| I I                                               | 14. Informant a. P. Ber w                                                                                                                                                                                                                       | 19. Place of Burial, Cremation, or Removal  Date of Burial  U-30 19 36                                                                                                                         |  |  |  |  |
| (& 0.34)<br>Write<br>R. B.                        | (Address)  15. Filed # - 30, 19 30 Registrary                                                                                                                                                                                                   | 20. Undertaker  Address  Address                                                                                                                                                               |  |  |  |  |
| 8                                                 | Registraty                                                                                                                                                                                                                                      | " 12 0:12                                                                                                                                                                                      |  |  |  |  |

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statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of Chank BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH No. Registration District No. 27 State File No. (If born in hospital or institution Prinz Registration District No. 2/19 Local Registrar's No. give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Sex of Legiti-Date of Triplet and in order Child 4 or other? mate? birth ... (To be answered only in event of plural births) (Month) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth..... (a) Born alive and now living.... FATHER FULL FULL NAME .. Residence (Usual place of alsode) Residence (Usual place of abode) \_ ruston I It non-resident, give place and 20to. If non-resident, give place and Stone Birthplace . Birthplace and State or County) (Olty and State or County) Occupation Occupation Access CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) (L \*Where there was no attending physician or midwife, then the father, householder, Physician or midwife: etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth.

WE SHILL THE STATE OF THE SECOND SECO COLUMN TO THE PARTAIEST OF THE PARTAIN BUHEAU OF TALESTANDE CENTRECARE OF MEETING Rosistantian District No. State Man Pair Meistration District No. 1,00al Meister M. CELL SAME CASE LIPER to some the word "Stupies" by some of the Tra manual digni (admid liable to topos in class hoperant so o l Solam (Months (News) (Year) What prophylacily was used to present contains required reconstorant? Poet allee but non don'd R. stience Usual place of shoots Il mus constanti gire place and Note autore consecuence of descriptions and sing ban will say amine and But Color of rest tend of the at less files to rolor Colon or money the state Alerent Pletoday COMMENT OF THE PERSON OF THE P The state of the s and bear of CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWISS t freeze could that a strenger the lairs of this child, was well sullbon (miletale) CHAPTER OF THE STREET, Comments to the server or midwife then the letter householder CHARLES A DESIGNATION OF THE PARTY OF ∧dd resa

| Ø .                                                                            | ·                                                                      | STATE OF IDAH                       | 0                                                                       |                                        |  |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------|----------------------------------------|--|
| <b>31</b>                                                                      | RECEIVED MAY 5 1930                                                    | DEPARTMENT OF PUBLIC                |                                                                         | JN THIS SPACE                          |  |
| 55                                                                             | PLACE OF DEATH BUREAU OF VITAL STA                                     |                                     | TISTICS                                                                 | 70211                                  |  |
| 120                                                                            |                                                                        | CERTIFICATE OF D                    | EATH State File No                                                      | عد الا وم " "                          |  |
| PHYSICIANS<br>t of OCCUPA-                                                     | County of Franklin Re                                                  | egistration District No2"           | 7                                                                       |                                        |  |
|                                                                                | Cities of Discontinuous                                                | imary Registration District N       | LOCAL REGISTA                                                           | ar's No                                |  |
| 'X',                                                                           | ri                                                                     | • •                                 |                                                                         | _                                      |  |
| ECORD<br>EXACTLY,<br>oct statemen                                              | (If death occurred in                                                  | No.                                 | ame instead of street and number.)                                      |                                        |  |
| Sta (                                                                          |                                                                        | 4.5                                 |                                                                         |                                        |  |
| RECORD<br>EXACT<br>tact state                                                  | 2. FULL NAME Stillborn P                                               | <del>-</del>                        |                                                                         | Ö                                      |  |
| 7.7                                                                            | (a) Residence. No                                                      |                                     | St. (If nonresident give city                                           | or town and State)                     |  |
| até l'a                                                                        | (Usual place of abode) Length of residence in city or town where death | occurred. yrs. mos. ds.             | How long in U. S., if of foreign birth?                                 | yrs. mos. ds.                          |  |
| NG PERMANENT hould be state y classified.                                      | PERSONAL AND STATISTICAL                                               | PARTICULARS                         | MEDICAL CERTIFICATE OF                                                  | DEATH                                  |  |
| MA<br>by Ag                                                                    |                                                                        |                                     | 16. DATE OF DEATH                                                       |                                        |  |
|                                                                                |                                                                        | or Divorced (write the word) Single | · Ar                                                                    | ril 29 1930                            |  |
| ING  N PERM  Should  rly clas                                                  |                                                                        | DINGIO                              |                                                                         | Day) (Year)                            |  |
|                                                                                | 5a. If married, widowed, or divorced<br>HUSBAND of                     |                                     | 17. I HEREBY CERTIFY, That I attended de                                | eceased from                           |  |
| BINI<br>IS A<br>AGE<br>prope                                                   | (or) WIFE of                                                           |                                     | , 19, to                                                                | , 19                                   |  |
| OR I                                                                           | 6. DATE OF BIRTH (month, day and year) A                               | pril 29.1930                        | that I last saw h alive on                                              | , 19                                   |  |
| FOR 1<br>THIS<br>ed. A                                                         | 7. AGE Years Months Day                                                | If LESS than 1 day,                 | and that death occurred, on the date stated abo                         | ve, atm.                               |  |
| 1 1 1 1 1 1                                                                    |                                                                        | hrs. or min.                        | The CAUSE OF DEATH* was as follows:                                     |                                        |  |
| RVEI<br>INK-<br>supp<br>t it n                                                 | 8. OCCUPATION OF DECEASED                                              |                                     | Cause unknown                                                           |                                        |  |
| SERVED FO  GINK—TH  Ily supplied.  hat it may l  certificate.                  |                                                                        |                                     | ######################################                                  | #1                                     |  |
| 15 PH 15 PM                                                                    | (a) Trade, profession, or No                                           | ne                                  |                                                                         | ······································ |  |
| Sefer B                                                                        | (b) General nature of industry,<br>business, or establishment in       |                                     | (duration)                                                              | _yrs ds.                               |  |
| NFA<br>NFA<br>ms, s                                                            | which employed (or employer)                                           |                                     | CONTRIBUTORY (Secondary)                                                |                                        |  |
| ARGIN<br>UNF<br>be ca<br>terms,<br>on back                                     | (c) Name of employer                                                   | T. Asha                             |                                                                         |                                        |  |
| <b>-</b>                                                                       | D                                                                      | at an Taba                          | (duration)                                                              | .yrs mos. ds.                          |  |
| MA<br>WITH<br>should<br>plain<br>iction o                                      | 9. BIRTHPLACE (city or town) Preston, Idaho (State or country)         |                                     | 18. Where was disease contracted if not at place of death?              |                                        |  |
| MA<br>PLAINLY, WITH<br>information should<br>DEATH in plain<br>See instruction | 10. NAME OF FATHER                                                     |                                     | Did an operation precede death?                                         | n ot/)                                 |  |
| LY<br>ion<br>H i                                                               |                                                                        | onzo Peton .                        | Was there an autopsy?                                                   |                                        |  |
| PLAINLY<br>formation<br>DEATH i                                                | 11. BIRTHPLACE OF FATHER (city or tow                                  | Preston Ideho                       | What test confirmed diagnosis?                                          | 17.0                                   |  |
| Se Se                                                                          | (State or Country)                                                     | VII)                                | (Signed) Oll MI                                                         | Olley M. D.                            |  |
| r in F                                                                         | 11. BIRTHPLACE OF FATHER (city or town (State or Country)  E           |                                     | April 309 30 (Address) Pre                                              | ,                                      |  |
| E 40 E                                                                         | 12. MAIDEN NAME OF MOTHER                                              | lla Geddes                          |                                                                         |                                        |  |
| VR)                                                                            |                                                                        |                                     | *State the DISEAST CAUSING DEATH, or                                    | in deaths from VIOLENT                 |  |
| WRITE<br>item of i<br>AUSE OF<br>important.                                    | 13. BIRTHPLACE OF MOTHER (city or to (State or Country)                | ston. Idaho                         | CAUSES, state (1) MEANS AND NATURI whether ACCIDENTAL, SUICIDAL, or HOM | ICIDAL.                                |  |
| ~ດ ~                                                                           |                                                                        | Paton                               | 19. Place of Burial, Cremation, or Removal                              | Date of Burial                         |  |
| -Every<br>state (<br>is very                                                   |                                                                        |                                     |                                                                         | 19                                     |  |
| 記され                                                                            | (Address) Pres                                                         | ton Idano                           | 20. Undertaker                                                          | Address                                |  |
| V. B<br>Hould                                                                  | 15. Filed, 19                                                          | IN Quela                            | zv. Underwiker                                                          | Address                                |  |
| - A C                                                                          | r iicu                                                                 | Registrar                           |                                                                         |                                        |  |

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia." unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the case of the constant of the control of the disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide: Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

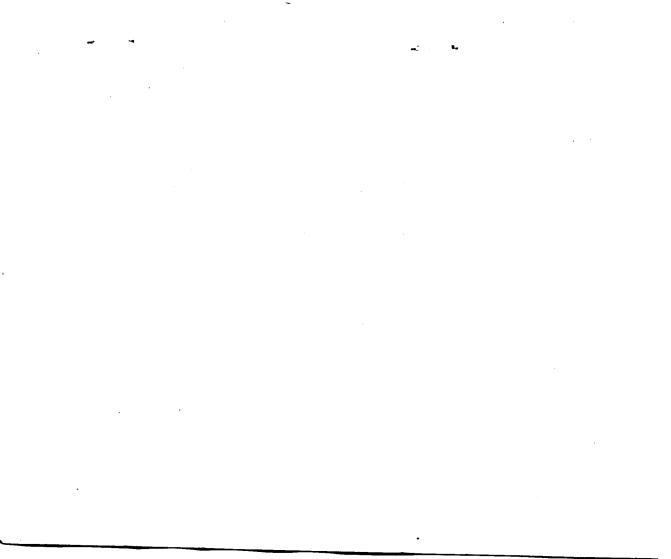
Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS County of CERTIFICATE OF BIRTH Registration District No......State File No...... Primary Registration District No......Local Registrar's No..... (Certificate of no value without full name of child) Number Twin Date of Legiti-Sex of Triplet in order or other? matel Child (Dav) (To be answered only in event of plural births) (Month) (Year) What bactericidal solution was used in eyes? Number of child of this mother, including present birth\_ Number of child of this mother now living, including present birth. FULL NAME COLOR COLOR CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was { Stillborn on the date above stated. \*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Give names added from a supplemental report. Registrar.



| A-S                                                                    | STATE OF IDAH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| PHYSICIAN<br>of OCCUPA                                                 | RECEIVED MAY 8 1930 DEPARTMENT OF PUBLIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | , 20 1101 (1202 22102 )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <u> </u>                                                               | PLACE OF DEATH BUREAU OF-VITAL-STA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| S O                                                                    | CERTIFICATE OF I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Ħ.A                                                                    | County of Registration District No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Local Registrar's No. /2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                        | City of Grangeville Primary Registration District                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | No. 2181 Local Registrar's No. 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| ECORD<br>EXACTLY,<br>ct statemen                                       | 11 or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 문단물                                                                    | (If death occurred in a hospital or institution, give its r                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | name instead of street and number.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                        | BULL NAME Baby Sillitt                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>y</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| RECORD Exact state                                                     | Z. FULL MARIE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | St                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 75.P3                                                                  | (a) Residence. No(Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (If nonresident give city or town and State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| ENT<br>stated<br>d. Es                                                 | Length of residence in city or town where death occurred. yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | now long in or si, it said                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 7 TO 1                                                                 | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Eig &                                                                  | The state of the s | 16. DATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| FRMAL<br>uld be<br>classifi                                            | 3. SEX 4. COLOR OR RACE or Divorced (write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| ING<br>PERI<br>should<br>rly cla                                       | Maria Control Rock Maria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (Brotton)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>೧</b> ≪ &                                                           | 5a. If married, widowed, or divorced HUSBAND of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 17. LHEREBY CERTIFY, That I attended deceased from Much 28, 1936, to 3-28, 1950.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| BINI<br>IS AGE<br>prope                                                | (or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2 28 80                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                        | 6. DATE OF BIRTH (month, day and year) 3-28-30                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | that I last saw heavy anve on                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| FOR THIS ed. 14 be                                                     | 7. AGE Years Months. Days If LESS than 1 day, hrs. or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | and that death occurred, on the date stated above, as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| _   := @ <del>*</del>                                                  | Qtill- born min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | The CAUSE OF DEATH* was as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| ESERVED ING INK-ully supplified it m that it m of certifical           | 8. OCCUPATION OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | had be an in a charaction                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>医</b> 一 中                                                           | 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | To Shorter work Count death to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| S S S S S S S S S S S S S S S S S S S                                  | (a) Trade, profession, or particular kind of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| RGIN RESE<br>UNFADING<br>be carefully<br>erms, so than<br>n back of ce | (b) General nature of industry,<br>business, or establishment in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | baby (duration) Oyrs. O mos. 6 ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| NFA<br>NFA<br>ms, car                                                  | which employed (or employer)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CONTRIBUTORY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| ARGIN<br>UNFA<br>be ca<br>terms,                                       | (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Secondary) (duration) yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>~</b> ~ ~ ~                                                         | a BIRTHPLACE (city or town) Granglvelle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10 Where was disease contracted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| MANTH<br>WITH<br>should<br>plain<br>ction                              | 9. BIRTHPLACE (city or town) (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | if not at place of death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| NLY, WITH ation should TH in plain instruction                         | 10. NAME OF FATHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Did an operation precede death? Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| LY,                                                                    | Boy Gillille                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Was there an autopsy?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| PLAINLY,<br>information<br>DEATH in<br>See instr                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What test confirmed diagnosis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| LAI<br>OFF<br>See                                                      | (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (Signed) M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                        | 11. BIRTHPLACE OF FATHER (city of town)  (State or Country)  12. MAIDEN NAME OF MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| RITE Of ir                                                             | 12. MAIDEN NAME OF MOTHER Stillitte                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| VRI<br>SE C                                                            | 12 PIPTUPLACE OF MOTHER (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| W WAUS                                                                 | (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| 524 'Every state                                                       | Informant                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | - Irangerice 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| S Z Z                                                                  | (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 20. Undertaker Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| ° 1 ■                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1) assar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| - [] <b>V</b> V                                                        | 1930. Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| W. 4                                                                   | Tilled Management                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine. etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife. Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH-Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF

INJURY and qualify as ACCIDENTAL, SUICIDAL, or

HOMICIDAL, or as probably such, if impossible to de-

termine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of

head-homicide; Poisoned by carbolic acid-probably sui-

cide. The nature of the injury, as fractured skull, and con-

sequences (e. g. sepsis, tetanus) may be stated under the

head of "Contributory."

spinal fever (the only definite synonym is "Epidemic

DUTY OF LOCAL REGISTRARS-Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

APR 2 1-1930 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County X BUREAU OF VITAL STATISTICS City CERTIFICATE OF BIRTH 180533 No. Registration District No..... ....State File No...... (If born in hospital or institution Prima Registration District No..... Local Registrar's No. give name.) FULL NAME OF CHILD.... (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number order of Triple in order birth . or other? (To be answered only in event of plural births) (Month) (Year) What prophylactic was used to prevent Ophthalmia Neopatorum? Number of child of this mother, including present birth Bern alive and now living .....(a) Born alive but now dead...... Residence (Usual place of about Residence (Usual place of aboth If non-rerident, tive place It non-resident, give place an Color or rece e at last Birthday Birthplace ..... (City and State or County) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was Stillbown on the date above stated. \*Where there was no attending physician or midwife, then the father, householder. etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after kirth. Filed.

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DIVISION OF VITAL STATISTICS

DEPARTMENT (F COMMERCE BUREAU OF VITAL STATISTICS

C.K. MACEY SPECIAL AGENT

Boise, Idaho

MAY 2 0 1930

Mrs. W. M. Otis Jerome BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Doar Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

| PLACE OF<br>BIRTH**                                                                                           | Jerome                     | DATE OF BIRTH                | 25, 1930                                                  | SEX OF Male                   |
|---------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------|-----------------------------------------------------------|-------------------------------|
| 2. Number 1                                                                                                   | born alive and r           | n to this mother, now living |                                                           |                               |
|                                                                                                               |                            | (Please write p              | lainly)                                                   |                               |
| Informa                                                                                                       | tion with reference FATHER | ence to                      | Info                                                      | rmation with reference MOTHER |
| 1                                                                                                             | (Full hame)                | <u> </u>                     | <del>- É</del>                                            | (Full Maiden name)            |
| <u> </u>                                                                                                      | (Residence)                |                              |                                                           | (Residence)                   |
| Age at las                                                                                                    | t birthday                 |                              | Age at last                                               | birthday                      |
| agar againn | (Birthplace)               |                              | <del>gangagan dan dan dan dan dan dan dan dan dan d</del> | (Birthplace)                  |
|                                                                                                               | (Occupation)               |                              |                                                           |                               |

matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C.K. Macey

Special Agent, Bureau of the Census.

|                                 | 743 206-070-743                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                 | PLACE OF BIPTIMINED ADD 1 7 1000                                                                                                                                                                           | STATE OF IDAHO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                 | RECEIVED APR 1 7 1930                                                                                                                                                                                      | BUREAU OF VITAL STATISTICS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                 | Coroney of                                                                                                                                                                                                 | CERTIFICATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| CORD                            | City of MUNNU Registration District No.                                                                                                                                                                    | 41 ** 180641                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| IENT RECORD<br>be made for each | NoSt.  Primary Registration Di                                                                                                                                                                             | strict No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| NG<br>MAN                       | FULL NAME OF CHILD                                                                                                                                                                                         | Muly                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| E < 24                          | Sex of Twin Triplet and Number in order or other? (To be answered only in event of plural bin                                                                                                              | ths) Logiti- Mo. Date of 4-6 30 C<br>Birth (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| FOR I                           | NAME SYNTATHER allen                                                                                                                                                                                       | MAIDEN MUNICH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| VED FCINK-THI                   | RESIDENCE BUILLY, Saa                                                                                                                                                                                      | RESIDENCE MOULENN,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| NG<br>NG<br>Pird                | COLOR AGÉ ATILAST BIRTHDAY (Years)                                                                                                                                                                         | COLOR AGE AT LAST BIRTHDAY(Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| RE<br>FA                        | BIRTHPLACE                                                                                                                                                                                                 | BIRTHPLACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| GIN<br>HUN<br>diben             | OCCUPATION CANULAW. PLA                                                                                                                                                                                    | OCCUPATION MISSING N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                 | Number of child of this mother, including present birth Number                                                                                                                                             | er of children of this mether now living, including present birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Σ ≻ اً                          | CERTIFICATE OF ATTENDIN  I hereby certify that I attended the birth of this child, who was on the date above stated.                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| WRITE PLAIN<br>N.B. Is esse     | When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. | 1,18 millon, mas                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>≯</b>                        | Given names added from a supplemental report.                                                                                                                                                              | Must de de la constant de la constan |
|                                 | Registrar Filed Africa                                                                                                                                                                                     | WO 1920 Clas Bellany Register                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

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FORM V. S. No. 5-25 M. 1-16-13 CERTIFICATE OF DEATH. State of Idaho PHYSICIANS BOARD OF HEALTH Registration District No. Bureau of Vital Statistics County of Primary Registration District No. 2 File No. Registered No. if death occurs away from If death occurred in a hosusual residence, give facts pital, institution or camp, give its NAME instead of called for under special information. FULL NAME street and number. PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEA 4. COLOR OR RACE 5. SINGLE, MARRIED, WID. 16. DATE OF DEATH 6. DATE OF BIRTH. (Month) (Dav) I HEREBY CERTIFY. That I attended deceased from (Dav) (Year 7. AGE IF LESS than 1 day that I last saw h.....alive on .....191....... how many ..... hrs. or and that death occured on the date stated above, at ......M. Yrs......ds. .....min.? 8. OCCUPATION (a) Trade, profession or particular kind of work...... (b) General nature of industry, business, or estab-lishment in which employed (or employer)..... 9. BIRTHPLACE (State or Country) (Secondary) 10. NAME OF 11. BIRTHPLACE E OF DEATH OCCUPATION OF FATHER (State or Country) \*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) 12. MAIDEN NAME Means of Injury; and (2) whether Accidental, Suicidal or Homicidal. 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) 13. BIRTHPLACE OF MOTHER At place of death.....yrs.....mos.....days. (State or Country) State.....yrs.....mos.....days Where was disease contracted 14. THE ABOVE IS S.—Every ite should state if not at place of death 15. SYMS - YORK CO., PTRS. & BORS. 24654

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager." "Dealer," etc., without more precise specifications, as Day laborer. Farm laborer. Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: Farmer (retired, 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUER-PERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train -accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis. tetanus) may be stated under the head of "Contributory."

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of ... Z BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH No. ----(If born in hospital or institution Pfim. Registration District No. 20/5 Local Registrar's No. 56 give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Number Twin Date of -Legiti-Sex of and in order Triplet birth ... or other? mate? Child. (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive and now living....... Born alive but now dead...... Stillborn ..... FULL MOTHER FATHER MAIDEN FULLC If non-resident, give place and It non-resident, give place and State Color or race... Birthplace A nd State or County) Occupation .... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) 4 WRITE \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

HERRICO CONTRACTO sollestient transmit at many With Resultantian District Mana 2 . Lond Destroy West No. PULL TANK OF CHELL bilds to some tot "atsidility" books out officially mandelling in Number derivid lands to some or des became at a presently neste were used to prevent Ophticalinia Reconstruction and it was been entire to the control of the contro Them follow the same done MAYMY Continue to the second of the second Color or race Lights in Age at last Misheley A Vehicle Birthaly भागका माहासा<u>ल</u> Orunnation ...... CONTRACTOR AND ASSESSED OF THE STREET, Librally certify that I attended the circle of this child, who was sellibora ( muterraig) ANTHER CHOPS HERE BY ANTHER THE STOLEN Called the to Repair villa or infinite, then the father, householder, ales strough confections return a attilisorn alille in one that residence but there are

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| ZZ                                                                     | RECEIVED DEC 1 1 1980                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                      | DO NOT TURKER TO                                        |                                                  |                 |
| 33                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DEPARTMENT OF PUBLIC<br>BUREAU OF VIPAL ST                                                           |                                                         | DO NOT WRITE IN                                  | THIS SPACE      |
| YSICIAN<br>OCCUP.                                                      | PLACE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                      | /                                                       | GL-4- TRIL N. ()                                 | 3858 L          |
| <b>20</b>                                                              | County of Muncowka CERTIFICATE OF I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                      |                                                         | State File No                                    |                 |
| PHY<br>of (                                                            | Re Re                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | gistration District No                                                                               | 19                                                      |                                                  | 1.11            |
|                                                                        | City of Pr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | imary Registration District                                                                          | No 2012                                                 | Local Registrar's                                | No. 6 7         |
| r RECORD<br>ed EXACTLY,<br>Exact statement                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                      | •                                                       |                                                  |                 |
| SE                                                                     | (If death occurred in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | lo                                                                                                   | name instead of street and                              | )                                                |                 |
| RECORD<br>EXACT                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2                                                                                                    | name makau or su eet anu                                | number.                                          | Ne              |
| 당첧늏                                                                    | 2. FULL NAME AUU V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <del>your</del>                                                                                      |                                                         |                                                  |                 |
| 24 T 88                                                                | (a) Residence. No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                      | Q+                                                      |                                                  | U               |
| <b>三</b> 桑田                                                            | (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                      | (                                                       | If nonresident give city or to                   | wn and State)   |
| EN.                                                                    | Length of residence in city or town where death of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ecurred. yrs. mos. ds.                                                                               | How long in U.S., if c                                  | of foreign birth? yrs.                           | mos. ds.        |
| DING<br>A PERMANENT<br>should be state<br>erly classified. E           | PERSONAL AND STATISTICAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | PARTICULARS                                                                                          | MEDICA                                                  | AL CERTIFICATE OF DEAT                           | .H              |
| 3<br>ERMA]<br>uld be<br>classifi                                       | 8. SEX 4. COLOR OR RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Single, Married, Widowed,                                                                            | 16. DATE OF DEAT                                        | 911                                              |                 |
| <sub>년</sub> 별 등                                                       | Le White                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | or Divorced (write the word)                                                                         | <u> </u>                                                | Mar 18                                           | 1030            |
| ING<br>PERI<br>should                                                  | Jan Muc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Cracy                                                                                                |                                                         | (Month) (Day)                                    | (Year)          |
|                                                                        | 5a. If married, widowed, or divorced<br>HUSBAND of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                      | 17. I HEREBY CERT                                       | IFY, That I attended deceased                    | from            |
| BINDIN<br>IS A P<br>AGE she<br>properly                                | (or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | mer 18, 1930, p. March 17, 1930                                                                      |                                                         |                                                  |                 |
| N A Q                                                                  | 6. DATE OF BIRTH (month, day and year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                      |                                                         | 14.50 /                                          |                 |
| FOR THIS ed. Asy be                                                    | 7. AGE Years Months Day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | that I last saw h                                                                                    | alive on                                                |                                                  |                 |
| K—TJ pplied may cate.                                                  | 7. AGE Years Months Days I LESS than 1 day,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      | and that death occurred, on the date stated above, atm. |                                                  |                 |
| SERVED FOR INK—TI supplied hat it may certificate.                     | - O This                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                      | The CAUSE OF DEAT                                       | TH* was as follows:                              |                 |
| RVE<br>INK<br>supp                                                     | 8. OCCUPATION OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 601                                                                                                  | fension 1                                               | our umbelied                                     | con.            |
| SSER<br>NG 1                                                           | (a) Trade, profession, or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | time of tension on some cut  off circulation (duration) yrs. mos. ds.  CONTRIBUTORY                  |                                                         |                                                  |                 |
| SE E E                                                                 | (a) Trade, profession, or particular kind of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                      |                                                         |                                                  |                 |
| RGIN RESE<br>UNFADING<br>be carefully<br>erms, so that<br>n back of ce | (b) General nature of industry,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                      |                                                         |                                                  |                 |
| K S G Y                                                                | business, or establishment in which employed (or employer)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                      |                                                         |                                                  |                 |
| UNFA<br>UNFA<br>be ca<br>terms,<br>on back                             | (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                      |                                                         |                                                  |                 |
| <b>—</b>                                                               | (0, 1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (Secondary)                                                                                          |                                                         |                                                  |                 |
| NLY, WITH<br>ation should<br>TH in plain<br>instruction                | 9. BIRTHPLACE (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      | (duration)yrs.                                          | mos. ds.                                         |                 |
| tigh X                                                                 | (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 18. Where was disease contracted if not at place of death?  Did an operation precede death?  Date of |                                                         |                                                  |                 |
|                                                                        | 10. NAME OF FATHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                      |                                                         |                                                  |                 |
| R High                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Head                                                                                                 |                                                         | _                                                |                 |
| PLAINLY<br>nformation<br>DEATH<br>See inst                             | 70                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | W :                                                                                                  | Was there an autopsy                                    | ***************************************          |                 |
| A EE                                                                   | 11. BIRTHPLACE OF FATHER (city or tow<br>(State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | n) signica                                                                                           | What test confirmed di                                  | agnosis                                          |                 |
| 도월요~                                                                   | 11. BIRTHPLACE OF FATHER (city or tow (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                      | (Signed)                                                | deland myn                                       | , M. D.         |
| 10000000000000000000000000000000000000                                 | 2 12. MAIDEN NAME OF MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 0+ 5                                                                                                 | , 19                                                    | (Address) Ruf                                    | est, Loho       |
| WRITE<br>m of i<br>ISE OF                                              | The state of the s | a annie                                                                                              |                                                         |                                                  |                 |
|                                                                        | 13. BIRTHPLACE OF MOTHER (city or to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                      | *State the DISEASE                                      | CAUSING DEATH, or in deat<br>IEANS AND NATURE OF | hs from VIOLENT |
| ir AT                                                                  | (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Mano                                                                                                 | whether ACCIDENTAL                                      | L, SUICIDAL, or HOMICIDA                         | L,              |
| WRITE F<br>-Every item of ini<br>state CAUSE OF I                      | 14. ON 11 11.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <i></i>                                                                                              | 19, Place of Burial, Co                                 | remation, or Removal   De                        | ate of Burial   |
| vei<br>ver                                                             | Informant                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      | 11 1 2                                                  |                                                  |                 |
| -Every<br>state<br>is very                                             | (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | - Lan                                                                                                | ocuper 1º                                               | emely the                                        | ar 191930       |
| 1                                                                      | 15.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 10                                                                                                   | 20 Vindertoker                                          | A                                                | idrges /        |
| N. B.<br>should<br>TION                                                | File 100. 6, 1938                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Ofmore                                                                                               | W. M. W.                                                | under 1                                          | Y.A.T           |
| 725                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Registrar                                                                                            | 21.0/.120                                               | 100000000000000000000000000000000000000          | myring_         |
|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                      |                                                         |                                                  | /               |

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia: Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of ...... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles: Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Charles," "Will. "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide: Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

(If born in hospital or institution Prim. Registration District No. 1.1.76. Local Registrar's No... give name.) FULL NAME OF CHILD.... (If stillborn, substitute the word "Stillbirth" for name of shild) Number Twin Date of Sex of Legiti-Triplet in order mate? Hes birth ... Child or other? (To be answered only in event of plural births) (Month) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth................. (a) Born alive and now living... Born alive but now dead..... .Stillborn ...... FULL MAIDEN NAME .... It non-resident, give place and State.... If non-resident, give place and State (City and State or County) (City and State County) CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFF. I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) 4 \*Where there was no attending physician? or midwife, then the father, householder, (Physician or midwice) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



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RECEIVED MAY 5 STATE OF IDAHO stated EXACTLY, PHYSICIANS d. Exact statement of OCCUPA-DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH State File No..... CERTIFICATE OF DEATH County of. Registration District No.... Local Registrar's No... Primary Registration District No. 3.1. A PERMANENT RECORD 2. FULL NAME. St. (a) Residence. No... (If nonresident give city or town and State) (Usual place of abode) How long in U. S., if of foreign birth? Length of residence in city or town where death occurred. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 16. DATE OF DEATH SEX COLOR OR RACE Single, Married, Widowed, should or Divorced (write the word) (Month) (Day) (Year) 5a. If married, widowed, or divorced HUSBAND of 17. I HEREBY CERTIFY. That I attended deceased from (or) WIFE of 6. DATE OF BIRTH (month, day and year) that I last saw h alive on Months Davs If LESS than 1 day, 7. AGE Years and that death occurred, on the date stated above, at hrs. or The CAUSE OF DEATH\* was as follows: 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in (duration) \_\_\_\_\_vrs. \_\_\_\_mos. which employed (or employer) CONTRIBUTORY (c) Name of employer (Secondary) \_\_\_\_\_(duration) \_\_\_\_\_yrs. \_\_\_\_mos. \_\_\_ds. 9. BIRTHPLACE (city or atow 18. Where was disease contracted (State or country) if not at place of death? ..... Did an operation precede death? Date of\_\_\_\_\_ 10. NAME OF FATHER f information OF DEATH i Was there an autopsy? What test confirmed disgussis PARENTS 11. BIRTHPLACE OF FATHER (city (State or Country) item of in AUSE OF important. 12. MAIDEN NAME OF MOTHER \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 13. BIRTHPLACE OF MOTHER (State or Country) Very 19. Place of Burial, Cremation, or Removal Date of Burial Informant (Address) 20. Undertaker Address

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1930 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of Le BUREAU OF VITAL STATISTICS City of..... CERTIFICATE OF BIRTH No. No. L. A. State, File No. مُرْسَةُ مَا يَا اللَّهُ وَالْمُوا وَالْمُوالِيُّ اللَّهُ اللَّهُ اللَّهُ وَاللَّهُ وَاللَّهُ وَالْمُ (If born in hospital or institution Prim. Registration District No. 2/76 Local Registrar's No. 3 give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number Legiti-Date of Sex of and Triplet birth Child or other? mate? 7 (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Stillborn \_\_\_\_ Born alive but now dead..... FILL MAIDEN Residence (Usual place of abode) UL Clark Residence (Usual place of abode) If non-resident, give place and State It non-resident, give place and State Color or race.... Birthplace ... (City and State or County) Acity and State or County) Occupation Lasser Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was Sitilborn on the date above stated. \*Where there was no attending physician or midwife, then the father, householder, (Physician er-midwife) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Registrar.

Market Market State and Service STATE OF IBARO DEPARTMENT OF PURISO WELLARS BURBLAU OF VITAL STATISTICS CERTIFICATE OF HEREN the state of the s notiution to father at the con-FULL VAME OR CHILD. (If stiller en, substitute the word "stillbirth" for side of shild) Twin humber free in order on others or others. Legitito resi Deld . Midd) (I'm be answered only in event of placed birtha) (EIGDM) What prophetic was used to provint Ophthalmia Noonatorum? Number of ohist of this mother, including present birth. ...... (a), Born allow and now living ..... Horn alive but now doug StUlborn ..... ROTHER PULL. MAIDEN HAHT Bill it Profession (County states of aborder) A numerident, give place and State. man design and the man state of the second (MICHT) Stirrhplace Birthplace County (Oit) and Rists or Coding) CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWING artis mail

Licroby certify that I attended the birth of this child, who was Stillborn on the date sinks stated. (Signature) \*Where there was no attending physician

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Physician or midwette)

| A-A                                                                                                                                                                                                                                                             | RECEIVED MAY 5 1930 DEPARTMENT OF PURI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                               |
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| ₹5                                                                                                                                                                                                                                                              | DIDEAU OF VIEW I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | DO NOT WHILE IN THIS STRUE                                                                                                                                    |
| - 222 ~                                                                                                                                                                                                                                                         | PLACE OF DEATH  CERTIFICATE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                               |
| FO                                                                                                                                                                                                                                                              | County of Clean Registration District No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                               |
| E O                                                                                                                                                                                                                                                             | City of City of Primary Registration District No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Local Registrar's No.                                                                                                                                         |
| X,                                                                                                                                                                                                                                                              | Primary Registration District                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | t No.5./                                                                                                                                                      |
| SE SE                                                                                                                                                                                                                                                           | (No(If death occurred in a hospital or institution, give it                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | s name instead of street and number.)                                                                                                                         |
|                                                                                                                                                                                                                                                                 | At the state of th |                                                                                                                                                               |
| WRITE PLAINLY, WITH UNRADING INK—THIS IS A PERMANENT REC item of information should be carefully supplied. AGE should be stated EXAUSE OF DEATH in plain terms, so that it may be properly classified. Exact important. See instruction on back of certificate. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | GL                                                                                                                                                            |
|                                                                                                                                                                                                                                                                 | (a) Residence. No(Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (if nonresident give city of town and state)                                                                                                                  |
| eta<br>d.                                                                                                                                                                                                                                                       | Length of residence in city or town where death occurred. yrs. mos. d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | s. How long in U. S., if of foreign birth? yrs. mos. ds.                                                                                                      |
| Fig. A.                                                                                                                                                                                                                                                         | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |
| RM<br>d ]                                                                                                                                                                                                                                                       | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorged (write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 16. DATE OF DEATH                                                                                                                                             |
| PEE                                                                                                                                                                                                                                                             | male w sincle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (Month) (Day) (Year)                                                                                                                                          |
| A la fr                                                                                                                                                                                                                                                         | 5a, If married, widowed, or divorced HUSBAND of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                           |
| IS IS                                                                                                                                                                                                                                                           | (or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 19 to 19                                                                                                                                                      |
| IS IS                                                                                                                                                                                                                                                           | 6. DATE OF BIRTH (month, day and year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | that I last saw h alive on , 19                                                                                                                               |
| ed.                                                                                                                                                                                                                                                             | 7. AGE Years Months Days If LESS than 1 day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | and that death occurred, on the date stated above, at                                                                                                         |
| ata a fi                                                                                                                                                                                                                                                        | min,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | The CAUSE OF DEATH* was as follows:                                                                                                                           |
| titis Ni                                                                                                                                                                                                                                                        | 8. OCCUPATION OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Markenoun marriated                                                                                                                                           |
| Lat Cer                                                                                                                                                                                                                     | (a) Trade, profession, or particular kind of work.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |
| of the latest                                                                                                                                                                                                                                                   | (b) General nature of industry.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                               |
| Ek g K A                                                                                                                                                                                                                                                        | business, or establishment in which employed (or employer)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (duration)yrsmosds.                                                                                                                                           |
|                                                                                                                                                                                                                                                                 | (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CONTRIBUTORY (Secondary)                                                                                                                                      |
| at 🕶 🙃                                                                                                                                                                                                                                                          | Olicha Adl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (duration)yrsmosds.                                                                                                                                           |
| tion of the                                                                                                                                                                                                                                                     | 9. BIRTHPLACE (city or town) (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 18. Where was disease contracted if not at place of death?                                                                                                    |
|                                                                                                                                                                                                                                                                 | 10. NAME OF FATHER 4/ 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Did an operation precede death? Date of                                                                                                                       |
| tion His                                                                                                                                                                                                                                                        | Leo to Challon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Was there an autopsy?                                                                                                                                         |
| AIN<br>Wana<br>Pe j                                                                                                                                                                                                                                             | 11. BIRTHPLACE OF FATHER (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What test confirmed diagnosts                                                                                                                                 |
| T of E                                                                                                                                                                                                                                                          | 11. BIRTHPLACE OF FATHER (city or town) (State or Country)  12. MAIDEN NAME OF MOTHER (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Signed) Machinerate, M. D.                                                                                                                                   |
| E TOT                                                                                                                                                                                                                                                           | 12. MAIDEN NAME OF MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | , 19 (Address) Dugge (FOA).                                                                                                                                   |
|                                                                                                                                                                                                                                                                 | madric therein                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT                                                                                                   |
| tem<br>TUS<br>In po                                                                                                                                                                                                                                             | 13. BIRTHPLACE OF MOTHER (city or town). (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
|                                                                                                                                                                                                                                                                 | 14. H. T. C. T.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 19. Place of Burial, Cremation, or Removal   Date of Burial                                                                                                   |
| Every<br>state (                                                                                                                                                                                                                                                | Informant Leo H. Shuston                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (1)                                                                                                                                                           |
| H. S. S. S.                                                                                                                                                                                                                                                     | (Address) Victor, Viloxbo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 20. Undertaker Address                                                                                                                                        |
| A B Z                                                                                                                                                                                                                                                           | 15. Filed 5-2- 1930 martne Marker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                               |
| Z.g.r.                                                                                                                                                                                                                                                          | Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                               |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs. meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inantion," "Marasmus," "Old age,"
"Stack," "Usonie," "Westerness," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

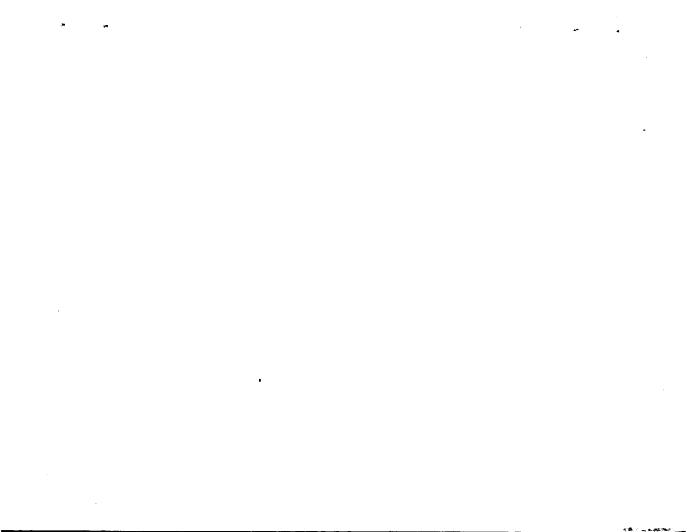
Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECORD be made for E-OF IDAHO DEPARTMENT OF PUBLIC WELFARE County BUREAU OF VITAL STATISTICS City of ..... CERTIFICATE OF BIRTH PERMANENT | RETURN must b th stated. Registration District No., State File No..... (If born in hospital or institution Local Registrar's No..... Prim. Registration District Mo. give name.) FULL NAME OF CHILD (If stillborn substitute the word "Stillbirth" for name of child) Number Date of Sex of Triplet in order birth Child or other? of birth (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum SEP. Number of child of this mother, including present birth (a) Born alive and now living Born alive but now dead. Stillborn FATHER FIILL FULL MAIDEN NAME UNFADING ne child at b Residence (Usual place of abode) Residence (Usual place of abode) If nonresident, give place and State If nonresident, give place and State Age at last Birthday. Color or race Color or rac Age at last Birthday one Birthplace Birthplace and State or Country) (City and State or Country) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* more PLAINLY I hereby certify that I attended the birth of this child, who was i Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, WRITE etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth.



|                                                            | STATE OF IDA                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                            | RECEIVED MAY 7 1930 DEPARTMENT OF PUBL                                                          | IC WELFARE DO NOT WRITE IN THIS SPACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 3 -                                                        | PUDEAU OF WITAL ST                                                                              | 1 w ( o o d 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| PHYSICIAN                                                  | County of Will CERTIFICATE OF                                                                   | DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 182                                                        |                                                                                                 | 17//                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Ħ                                                          | City of Registration District No.                                                               | • • 11/-1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| H                                                          | Primary Registration District                                                                   | No. Local Registral's No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| ≱                                                          |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Sed T                                                      | At death ocurred in 'a hospital or institution, give                                            | its name instead of street and number.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| EXACTI<br>Jassified<br>on back                             | 2. FULL NAME WOOD CASSALLA CULLA                                                                | mag                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                            |                                                                                                 | St. (If nonresident give city or town and State.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                            | (Usual place of abode.)  Length of residence in city or town where death occured.   yrs.   mos. | ds. How long in U. S. if of foreign birth? yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| D.<br>e stated<br>properly<br>istruction                   |                                                                                                 | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Stries.                                                    | PERSONAL AND STATISTICAL PARTICULARS                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| E g ag air                                                 | 8. SEX 4. COLOR OF RACE 5. Single Farried, Widowed, or Divorced (write the word.)               | 16. DATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| _ ಗಳ ಸ                                                     | Cleude White Blight                                                                             | (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| E R S E                                                    | 5a. If married, widowed, or divorced                                                            | (Month)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| N T S                                                      | HUSBAND of (or) WIFE of                                                                         | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| t BIP<br>ANEN<br>AGE<br>that<br>porta                      | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                                           | to O.C.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| FOR BIND<br>RMANENT<br>d. AGE s<br>so that it<br>important | 6. DATE OF BIRTH (month, day and year)                                                          | that I last saw anve on 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| F. E. S.               | 7. AGE Years Months Days If LESS than 1 day,hrs. or                                             | and that death occurred, on the date stated above, at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| RVED FOR Supplied.                                         | n n min.                                                                                        | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| RV<br>Suppose                                              | 8. OCCUPATION OF DECEASED                                                                       | whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH* was as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                            | (a) Trade, profession, or particular kind of work                                               | Mieroserbolus - Failure 2 devel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| IN RESCAPED CARETURE I IN PRATIO                           |                                                                                                 | the state of the s |
| N Hard                                                     | (b) General nature of industry, business, or establishment in                                   | ofinent occipiles regerso                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| ARGI<br>NK-<br>be ca<br>ATH<br>CCUP                        | which employed (or employer)                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| · 4 H=20                                                   | (c) state of chapter                                                                            | (duration)yrsmosds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| ' P . D .                                                  | 9. BIRTHPLACE (city or town) (State or country)                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ADING<br>a shou<br>E OF 1                                  |                                                                                                 | CONTRIBUTORY (Secondary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| CAUSE 0                                                    | 10. NAME OF FATHER                                                                              | dsds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| DAU<br>AU                                                  | - Squices animies                                                                               | 18. Where was disease contracted if not at place of death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                            | 2 11. BIRTHPLACE OF FATHER (city or town). (State or Country)                                   | Did an operation precede death? Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| act in E                                                   | 11. BIRTHPLACE OF FATHER (city or town) (State or Country)  12. MAIDEN NAME OF MOTHER           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Ext &                                                      | 12. MAIDEN NAME OF MOTHER                                                                       | Was there an autopsy?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| X g d                                                      | 18. BIRTHPLACE OF MOTHER city or town                                                           | (Signed) M. D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 돌粪첉                                                        | (State or County)                                                                               | 4-7 1030 (Address) Blefil                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| WRITE PLAU<br>N. B.—Every 1                                | ii Menti                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                            | Informant Cooledan Of                                                                           | 19. Nace of Burial, Cremation, or Removal  Date of Burial  7 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                            | (Address) Trull XXII.                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                            | 15. Filed A - 17 1930 J. Hurbly                                                                 | 20. Underwier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| PZ                                                         | Filed 4 - 1 1820 Registrar.                                                                     | I Offenusau Quel das                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| ,                                                          |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| _                                                          | / •                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

STATEMENT OF OCCUPATION.—Precise statement of o supation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery: (a) Foreman, (b) Automobile Factory, The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc. without more precise specifications, as Day laborer Farm laborer. Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 vrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidmic cerebrospinal meningitis"); Diptheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia"); Lobar Pneumonia: Bronchopneumonia ("pneumonia," unqualified, is indefite); Tuberculos's of lungs, meninges, peritoneum, etc., Careinoma, Sarcoma, etc., of ...... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms: Measles; Whooping Cough; Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy." "Exhaustion." "Heart Failure," "Hemorrhage." "Inanition." "Marasmus." "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide: Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

| •                           | PLACE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STATE ORIGINAL MED APR 19 1930                                        |
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|                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS               |
| 4                           | County of Cacca                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CERTIFICATE OF BIRTH                                                  |
| 9:                          | City of Cascalle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | CERTIFICATE OF BIRTH 180858                                           |
| RECOR                       | NOST 209 043 623st. Registration Distric                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | t No. 25 File No.                                                     |
| M 8                         | Hospital Primary Registration                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | n District No                                                         |
| E P                         | Janah 18                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ind Still Z. W                                                        |
| ANEN<br>must 1              | FULL NAME OF CHILD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ificate of no value without full name of child.)                      |
| ZZ                          | Twin Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | incate of no value without full finishe of cirila.)                   |
| PER<br>ETUR<br>h stat       | Child Triplet and in order of birth (To be answered only in event of plural by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | birth. Date of Man 4 430 (Month) (Day) (Year)                         |
| IS A                        | What bactericidal solution was used in eyes?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <i>V</i>                                                              |
| STA:                        | Number of child of this mother, including present birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | umber of children of this mother now living, including present birth. |
| IK—THI<br>EPARA<br>in order | FULL DANG FATHERING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | FULL MOTHER AND                   |
| the S                       | RESIDENCE Curade, Ida                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | RESIDENCE LA LA                                                       |
| ADIN<br>Lat bir<br>ber of   | COLOR Walter AGE AT LAST 43 BIRTHDAY (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | COLOR AGE AT LAST 2 BIRTHDAY(Years)                                   |
| UNI<br>obile<br>num         | BIRTHPLACE Josh Carolina                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | BIRTHBOACE SLAND                                                      |
| WITH<br>an one              | OCCUPATION Miner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | OCCUPATION Housewife                                                  |
| 7. di                       | CERTIFICATE OF ATTEND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | IN PHYSICIAN OR MIDWIFE # # PM                                        |
| AIN                         | I hereby certify that I attended the birth of this child the on the date above stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (Born at tear stillborn)                                              |
| PL 0                        | *When there was no attending physician or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | John Preide                                                           |
| WRITE                       | midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of the state of the | Talle                                                                 |
| <b>A a</b>                  | (dence of life after birth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (Physician or medwife)                                                |
| ż                           | Addres                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | esserce, sucho,                                                       |
|                             | Filed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 192 Stella Carre                                                      |
| ľ                           | Dadistan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Pagiotror                                                             |

| A -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | RECEIVED APR 19 1030 STATE OF IDAI                                                   |                                                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| AF.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | RECEIVED JUN 2 1 (30 DEPARTMENT OF PUBLIC                                            | C WELFARE DO NOT WRITE IN THIS SPACE                                                                                                                          |
| SPELA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | PLACE OF DEATH BUREAU OF VITAL ST                                                    |                                                                                                                                                               |
| YSI<br>OC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | County of County of CERTIFICATE OF                                                   |                                                                                                                                                               |
| E S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Registration District No                                                             | /5                                                                                                                                                            |
| ent,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | City of Primary Registration District                                                | No Local Registrar's No                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (No                                                                                  | )                                                                                                                                                             |
| ORD<br>ACTL<br>statem                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (No(If death occurred in a hospital or institution, give its                         | name instead of street and number.)                                                                                                                           |
| RECORD<br>EXACTLY,<br>tact statemen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2. FULL NAME Infant Vand                                                             | <u> </u>                                                                                                                                                      |
| A. W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                      | St.                                                                                                                                                           |
| YT 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (a) Residence. No                                                                    | (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.                                                            |
| St. St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Length of residence in city or town where death occurred. yrs. incs. us.             |                                                                                                                                                               |
| DING<br>A PERMANENT<br>should be state<br>rrly classified. E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | PERSONAL AND STATISTICAL PARTICULARS                                                 | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |
| 2 P.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 3. SEX 4. COLOL OR RACE 5. Single, Married, Widowed, or Divorced (write the word)    | 16. DATE OF DEATH                                                                                                                                             |
| PEG /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Tem White Single                                                                     | (Month) (Day) (Year)                                                                                                                                          |
| BINDING IS A PE AGE shou                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5a. If married, widowed, or divorced<br>HUSBAND of                                   | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                           |
| IS IS IS IS IS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (or) WIFE of                                                                         | 17. I HEREBI CERTIFI, That I attended deceased from                                                                                                           |
| A A B                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 6. DATE OF BIRTH (month, day and year March, 9 5 /930                                | that I last saw h. alive on , 19                                                                                                                              |
| FOR 1<br>THIS<br>ed. A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 7. AGE Years Months Days If LESS than 1 day,                                         |                                                                                                                                                               |
| K—T<br>pplied<br>may<br>cate.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | hrs. or                                                                              | and that death occurred, on the date stated above, at                                                                                                         |
| SERVED FOR INK—THE IN Supplied. hat it may let certificate.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | min.                                                                                 | The CAUSE OF BEATH was as follows:                                                                                                                            |
| <b>E</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 8. OCCUPATION OF DECEASED                                                            | Still out                                                                                                                                                     |
| SE SE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (a) Trade, profession, or particular kind of work                                    |                                                                                                                                                               |
| eft DI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (b) General nature of industry,                                                      | (3                                                                                                                                                            |
| GIN NFA NFA Survey                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | business, or establishment in which employed (or employer)                           | (duration)yrsmosds.                                                                                                                                           |
| E S S S S S S S S S S S S S S S S S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (c) Name of employer                                                                 | CONTRIBUTORY (Secondary)                                                                                                                                      |
| · · · · · · · · · · · · · · · · · · ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | A                                                                                    | (duration)yrsmosds.                                                                                                                                           |
| MA<br>PLAINLY, WITH<br>nformation should<br>DEATH in plain (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 9. BIRTHPLACE (city or town) (State or country)                                      | 18. Where was disease contracted                                                                                                                              |
| sh w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                      | if not at place of death?                                                                                                                                     |
| CY,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 10. NAME OF FATHER                                                                   | Did an operation precede death? Date of                                                                                                                       |
| PLAINLY<br>nformation<br>DEATH i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 7100110                                                                              | Was there an autopsy?                                                                                                                                         |
| SEE LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11. BIRTHPLACE OF FATHER city or own) (State or Country)  12. MAIDEN NAME OF MOTHER. | What test confirmed magnosis?                                                                                                                                 |
| a ju                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | In John Chira                                                                        | (Signed) Sawy, Survey & Corner                                                                                                                                |
| ant in the state of the state o | 12. MAIDEN NAME OF MOTHER                                                            | Address Carled office                                                                                                                                         |
| WRITE<br>item of i<br>AUSE OF<br>important.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Feet Good of                                                                         | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT                                                                                                   |
| ifter A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 13. BIRTHPLACE OF MOTHER (city or town) (State or Country)                           | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| Y C'                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 14. COTOLINA William                                                                 | 19. Place of Baria, Cremation or Removal Date of Burial                                                                                                       |
| ver<br>ver                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Informant Informant                                                                  | NO 21 193 4 3/ 193 4                                                                                                                                          |
| -Every<br>state C<br>is very                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (Address)                                                                            | all the form                                                                                                                                                  |
| \ # <b>#</b> 4.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 15. Files Much 9 19.30 Stilla Cain                                                   | 20. Undertaker Address                                                                                                                                        |
| N. B.<br>Bhould<br>TION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Registrar                                                                            | - France                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                      | •                                                                                                                                                             |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia: Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of ...... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No..... State File No..... Prim. Registration District No. Local Registrar's No. (If born in hospital or institution give name.) FULL NAME OF CHILD .... (If stillborn, substitute the word "Stillbirth" for name of child) Number Twin Date of Legiti-Sex of in order 7 Triplet birth mate? or other? Child (Month) (To be answered only in event of plural births) (Year) order What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead ... FULL MAIDEN FIII.L. NAME .... number Residence (Usual place of abode). If non-resident, give place and State...... It non-resident, give place and State Color or race.. Color or race...... Birthplace Birthplace ..../ Bud Occupation ..... Occupation ...... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was | Stillborn on the date above stated. (Signature) \*Where there was no attending physician Physician or midwire or midwife, then the father, householder, etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth. Registrar.

tyreugh to the tax the seamon the (City and State ... County) Occupation when we were CERTIFICATE OF ATTENDING PHYSICIAN OR MINVIPE.

I hereby corefly that I attended the birth of this child, who supplied diffluence hat

(Sixuature) Miles there was an attending physician or igiderife, then the father, householder, etc. should make this solure. I stillborn estid is one that relies breathes not study after better berth.

Address

Presiden or midwife

FORM V. S. No. 5-25 M. 1-19. STATE OF IDAHO RECORD CTLY, PHYSICIANS should CERTIFICATE OF DEATH DEPARTMENT OF PUBLIC WELFARE PLACE OF DEACH MA BUREAU OF VITAL STATISTICS Registration District No. State File No. 703 Primary Registration District No. 2/78 Local Registrar's No...... City of... If death occurred in a hos-If death occurs away from pital, institution or camp, usual residence, give facts give its NAME instead of called for under special in-2. FULL NAME street and number. formation. PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH 4. COLOR OR BACE 5. SINGLE, MARRIED, WID-R. SEX OWED OR DIVORCED 16. DATE OF DEATH the word) 6. DATE OF BIRTH I HEREBY CERTIFY, That I attended deceased from 17. (Day) (Year) (Month) 7. AGE IF LESS than 1 day how many .....hrs. The CAUSE OF DEATH! was as follows: Yrs Mos ds 8. OCCUPATION (a) Trade, profession or particular kind of work..... (b) General nature of industry, business or establishment in which employed (or employer)..... (Secondary) 9. BIRTHPLACE .....(Duration) (State or Country) 10. NAME OF Father 11. BIRTHPLACE \*State the Disease Causing Death; or in death's from Violent OF FATHER Causes, state (1) Means of Injury; and (2) whether Accidental, (State or Country) Suicidal or Homicidal, 12. MAIDEN NAM 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) 13. BIRTHPLACE At place In the of death.....yrs.....mos......days. State.....yrs....mos.......ds. OF MOTHER (State or Country) Where was disease contracted if not at place of death?.... Former or usual residence emelane

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer. Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Sales. man, (b) Grocery: (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager." "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife. Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS City of. CERTIFICATE OF BIRTH Registration District No. /OU State File No. Prim. Registration District No. 21.2. Local Registrar's No. 8. (If born in hospital or institu**et**) give name.) FULL NAME OF CHILI (If stillborn, substitute the word "Stillbirth" for name of child) Number Date of Sex of in order and d Triplet birth Child or other? (To be answered only in event of plural births) (Month) (Dav) (Year) What prophylactic was used to prevent Ophthalmia Neonal rum? Number of child of this mother, including present birth. 6 (a) Born alive and now living. Born alive but now dead 2 5 FULL It non-resident, give p If non-resident, give place and State (Years) (Years) Birthplace ..... Birthplace ..... or County) City and State or County Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder. (Physician or midwife etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Registrar.

The south the control of the control Print Lieutetration Matrice Sign Logic Sector for Secto ell stiflugen, cabalitute the word, "Stiffpiete for many and all the Yedning. tank) (dinole) ( tried lastic to some or view between ad a ) What profibelease was again to prevent Ophthaliada Neons (again) modifile Renderer Land place of ale Colds or racy The same of the sa (vinue) to said and Heart Day Vinte PRETINGATE OF ATTROUBED PRESIDENCE OR MENTERS Avertin and I been to the that I shall all the high of this thirt, who can littleborn on the rate above stared. Minimum. "There them was no attending physician (Physician of widesic) or midwile, then the lather, howesholder. ou should make this return. A at allown outed in out that neither breather nor shows other evidence of the settle serial. 5 1930 18 (50)

| PORMY S, No. 6-28 May 100 CENTIFICATE OF DEATH  OCHAN OF DEPARTMENT OF THE PROPERTY OF DEATH  COUNTY of Mandeth Course away from usual readence, give factor with the open of the course away from usual readence, give factor with the open of the course away from usual readence, give factor with the open of the course away from usual readence, give factor with the open of the course of the course away from usual readence, give factor with the open of the course away from usual readence, give factor with the open of the course of th | <b>~</b> 5 ∞                                | FORM V. S. No. 5-25 M. 1-19 MAY 1 6 130 CERTIFICATE 0                | E DEATH STATE OF IDAHO                                                                    |
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| County of Manager Primary Registration District No. State File No. A County of Manager Primary Registration District No. State File No. A County of Manager Primary Registration District No. State File No. A County of Manager Primary Registration District No. State File No. A County of Manager Primary Registration District No. State File No. A County of Manager Primary Registration District No. State File No. A County of Manager Primary Registration District No. State File No. A County of Manager Primary Registration District No. State File No. A County of Manager Primary Registration District No. State File No. A County of Manager Primary Registration District No. State File No. A County of Manager Primary Registration District No. State File No. A County of Manager Primary Registration District No. State File No. A County of Manager Primary Registration District No. State File No. A County of Manager Primary Registration District No. State File No. A County of Manager Primary Registration District No. A County of Manager Primary Registration No. A County of Manager Primary No. A County of Manager Primary No. A County of Manager Primary  | DO N                                        | 1. > REGEOF DEAMAN 1 0 ROU CERTIFICATE O                             |                                                                                           |
| PERSONAL AND STATISTICAL PARTICULARS  SEX 4. CULOR OR BACE IS SINGLE, MARKED, WID- OWER OF BIETH  (Write the word)  (Month) (Day) (Year)  If, LESS than 1  day how many and that death occurred on the date stated above, at 19  30 AUGUSTATION  S. OCCUPATION  S. OC | ₹ <u>5</u>                                  | Registration District No                                             | 776365                                                                                    |
| PERSONAL AND STATISTICAL PARTICULARS  SEX 4. CULOR OR BACE IS SINGLE, MARKED, WID- OWER OF BIETH  (Write the word)  (Month) (Day) (Year)  If, LESS than 1  day how many and that death occurred on the date stated above, at 19  30 AUGUSTATION  S. OCCUPATION  S. OC | 25 I                                        |                                                                      | let No. 2/18 State File No.                                                               |
| PERSONAL AND STATISTICAL PARTICULARS  SEX 4. CULOR OR BACE IS SINGLE, MARKED, WID- OWER OF BIETH  (Write the word)  (Month) (Day) (Year)  If, LESS than 1  day how many and that death occurred on the date stated above, at 19  30 AUGUSTATION  S. OCCUPATION  S. OC |                                             | (No                                                                  | / Local Registral & Romania American                                                      |
| PERSONAL AND STATISTICAL PARTICULARS  SEX 4. CULOR OR BACE IS SINGLE, MARKED, WID- OWER OF BIETH  (Write the word)  (Month) (Day) (Year)  If, LESS than 1  day how many and that death occurred on the date stated above, at 19  30 AUGUSTATION  S. OCCUPATION  S. OC | 55 l                                        | if death occurs away from                                            |                                                                                           |
| PERSONAL AND STATISTICAL PARTICULARS  SEX 4. CULOR OR BACE IS SINGLE, MARKED, WID- OWER OF BIETH  (Write the word)  (Month) (Day) (Year)  If, LESS than 1  day how many and that death occurred on the date stated above, at 19  30 AUGUSTATION  S. OCCUPATION  S. OC | <b>2</b> 00                                 | usual residence, give facts                                          | give its NAME instead of                                                                  |
| PERSONAL AND STATISTICAL PARTICULARS  SEX 4. CULOR OR BACE IS SINGLE, MARKED, WID- OWER OF BIETH  (Write the word)  (Month) (Day) (Year)  If, LESS than 1  day how many and that death occurred on the date stated above, at 19  30 AUGUSTATION  S. OCCUPATION  S. OC | _ E <sub>ω</sub>                            | formation. 2. FULL NAME Day                                          | street and number.                                                                        |
| THE STATE OF BIETH    Continue of the state of country   Continue of the state of coun | NENT RECOR<br>d EXACTLY,<br>act statement   | 8. SEX 4. COLOR OR BACE 5. SINGLE, MARRIED, WID-<br>OWED OR DIVORCED | 16. DATE OF DEATH Copie 19-                                                               |
| TARRENT CERTIFY, That I algeded decessed from that I last saw h. M. 19. 19. 19. 19. 19. 19. 19. 19. 19. 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | X E S                                       | R. DATE OF RIRTH                                                     | (Month) (Day) (1985)                                                                      |
| S. OCCUPATION  (a) Thade, profession or particular kind of work.  (b) General nature of industry, business or establishment in which employed (or employer).  S. BIRTHPLACE  (State or Country)  S. BIRTHPLACE  (State or Country)  OF FATHER  (State or Country)  MAIDEN NAME  OF MOTHER  (State or Country)  MAIDEN NAME  NAME  State the Disease Causing Death; or in deaths from Violent  Causes, state (1) Means of Injury; and (2) whether Accidental,  Suitcidal or Homicidal  IS. LENGTH OF RESIDENCE  (For Hospitals, Institutions,  Transleats or Recent Residents,  Mainen  State the Disease Causing Death; or in deaths from Violent  Causes, state (1) Means of Injury; and (2) whether Accidental,  Suitcidal or Homicidal  IS. LENGTH OF RESIDENCE  (For Hospitals, Institutions,  Transleats or Recent Residents,  Now Mainen | BINDING IS A PERM should be sta classified. | (Month) (Day) (Year)  7. AGE  IF LESS than 1 day how many hrs. or    | that I last saw h. At. ellipson 19.  and that death occurred on the date stated above, at |
| (a) Bade, profession or particular kind of work (b) General nature of industry, business or establishment in which employed (or employer).  9. BIRTHPLACE (State or Country)  11. BIRTHPLACE (State or Country)  12. MAIDEN NAME OF FATHER (State or Country)  12. MAIDEN NAME (State or Country)  13. BIRTHPLACE (State or Country)  14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Address)  15. Mark of Mornard (Address)  16. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)  16. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Address)  17. The ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Address)  18. BIRTHPLACE (For Hospitals, Institutions, Transients or Recent Residents, At place of death. Transients or Recent Residents, At place of death. The ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)  18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents, At place of death. Transients or Recent Residents. At place of death. Transients or Recent Residents. At place of death. The Mornard of the Mornar |                                             | Yrs Mos min.?                                                        | THE CAUSE OF DEATH. Was as follows:                                                       |
| (a) Bade, profession or particular kind of work (b) General nature of industry, business or establishment in which employed (or employer).  9. BIRTHPLACE (State or Country)  11. BIRTHPLACE (State or Country)  12. MAIDEN NAME OF FATHER (State or Country)  12. MAIDEN NAME OF FATHER (State or Country)  13. BIRTHPLACE (State or Country)  14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Address)  15. Translents or Recent Residents, Institutions, Translents or Recent Residents, at place of death. The property of the property |                                             |                                                                      | manua T                                                                                   |
| particular kind of work. (b) General nature of industry, business or establishment in which employed (or employer).  9. BIETHPLACE (State or Country)  10. NAME OF Father (State or Country)  11. BIRTHPLACE (State or Country)  12. MADEN NAME OF MOTHER  13. BIRTHPLACE (State or Country)  14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  15. Where was disease contracted if not at place of death?  16. MADEN OF MOTHER  17. Translents or Recent Residents.)  At place (Address)  18. BIRTHPLACE (State or Country)  19. MADEN NAME (State or Country)  10. NAME OF  10. NAME OF  11. BIRTHPLACE (State or Country)  12. MADEN NAME (State or Country)  13. LENGTH OF RESIDENCE (For Hospitals, Institutions, Translents or Recent Residents.)  19. MADEN NAME (State or Country)  19. MADEN NAME (State | TED (K)                                     |                                                                      | maceralia forlis                                                                          |
| Contributory State or Country  State or Country  State or Country  The part of | PAIN S                                      | particular kind of work                                              |                                                                                           |
| Contributory State or Country  State or Country  State or Country  The part of | G. P. C.                                    | (b) General nature of in-                                            | 4- 4- 4- 4-                                                                               |
| Contributory (Secondary)  9. BIRTHPLACE (State or Country)  9. BIRTHPLACE (State or Country)  9. Father  11. BIRTHPLACE OF FATHER (State or Country)  12. MAIDEN NAME OF MOTHER  13. BIRTHPLACE OF MOTHER  14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  15.   16.   17. BIRTHPLACE (Signed)  18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Translents or Recent Residents.)  18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Translents or Recent Residents.)  19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  20. UNDERTABLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 37 35 E                                     | dustry, business or estab-                                           | (Duration)yrs                                                                             |
| B. BIRTHPLACE  (State or Country)  (Signed)  (Signed)  (State or Country)  (State or C |                                             |                                                                      |                                                                                           |
| (Signed)  (Signed)  (Signed)  (Signed)  (Signed)  (Signed)  (Signed)  (State or Country)  (State the Disease Causing Death; or in deafns from Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal or Homicidal.  (In Head or Country)  (State or Country)  (Signed)  (Address)  (Near State the Disease Causing Death; or in deafns; or in | er tre                                      | 9. RIRTHPLACE                                                        |                                                                                           |
| 10. NAME OF Father  11. BIRTHPLACE OF FATHER (State or Country) 12. MAIDEN NAME OF MOTHER  13. BIRTHPLACE OF MOTHER  (State or Country) 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  15. Maidense Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.  18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Translents or Recent Residents.)  At place In the of deathyrsmosdays_ Stateyrsmosds.  Where was disease contracted if not at place of death?Former or usual residence  (Address)  15                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 77                                          | (State or Country Jug expelle Bland                                  | (Duration)vrs                                                                             |
| OF FATHER  (State or Country)  12. MAIDEN NAME OF MOTHER  18. BIRTHPLACE OF MOTHER  (State or Country)  18. BIRTHPLACE OF MOTHER  (State or Country)  18. BIRTHPLACE OF MOTHER  (State or Country)  14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  (Address)                                                                                                                                                                                                                                                           |                                             |                                                                      |                                                                                           |
| Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal or Homicidal.  12. MAIDEN NAME OF MOTHER  18. BIRTHPLICE OF MOTHER  (State or Country)  18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  At place In the of death yrs mos days, State yrs mos days, State yrs mos days. State or country if not at place of death?  14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE if not at place of death?  (Address)  (Address)  15. Y  16. Y  17. PLACE OF BURIAL OR REMOVAL DATE UF BURIAL  19. PLACE OF BURIAL OR REMOVAL DATE UF BURIAL  20. UNDERTAKE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | holin h                                     |                                                                      | *State the Disease Causing Death; or in deaths from Violent                               |
| OF MOTHER  OF MOTHER  OF MOTHER  OF MOTHER  (State or Country)  (Address)  (A | LY<br>n s<br>fn s                           | OF FATHER (State or Country)                                         | Causes, state (1) Means of Injury; and (2) Whether Accidental,                            |
| OF MOTHER  OF MOTHER  OF MOTHER  OF MOTHER  (State or Country)  (Address)  (A | t to a series                               |                                                                      |                                                                                           |
| (State or Country)  Where was disease contracted if not at place of death?  Former or usual residence  (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | -4 62 . 123                                 |                                                                      | 18. LENGTH OF RESIDENCE (For Hospitals, Institutions,                                     |
| (State or Country)  Where was disease contracted if not at place of death?  Former or usual residence  (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | TE P<br>inford<br>TH i<br>instru            | 18. BIRTHPLACE                                                       | At place In the                                                                           |
| (Informant)  (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | S E E                                       | (State or Country) Messeo                                            | Where was disease contracted                                                              |
| (Address) (Addre | · # 2                                       | 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE                    |                                                                                           |
| ADDRESS 20. UNDERTAINE ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | # 0 # 0                                     | 2000                                                                 | Former or                                                                                 |
| ADDRESS 20. UNDERTAINE ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ₽₩ <b>₫</b>                                 |                                                                      |                                                                                           |
| ADDRESS 20. UNDERTAINE ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Ve.<br>Por                                  | (Address)                                                            | 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL                                             |
| ADDRESS 20. UNDERTAKER ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>73 [</b>                                 | 15. Y/ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~                           |                                                                                           |
| - I descend                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | N. B.<br>state<br>very                      |                                                                      |                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                             |                                                                      | U To Company                                                                              |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor. Architect, Locomotive engineer. Civil engineer. Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman. (b) Grocery: (a) Foreman. (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"): Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia: Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of .....(name origin; "Cancer' is less definite; avoid use of "Tumor" for malignant neoplasms: Measles: Whooping cough: Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death). 29 ds.: Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse." "Coma," "Convulsions," "Debility," ("Congental." "Senile." etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock." "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUER-PERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train -accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis. tetanus) may be stated under the head of "Contributory."

| NENT RECORD URN must be made tated.         | PLACE OF DIBTH ED MAY 16 1930  County of DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS  CERTIFICATE OF BIRTH S 180877  Registration District No. State File No.  (If born in hospital or institution give name.)  Prim. Registration District No. 20 Local Registrar's No. 20                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| A PERMANENT SATE REFURN m. of birth stated. | FULL NAME OF CHILD.  (If stillborn, substitute the word "Stillbirth" for name of child)  Sex of Child   Twin   And   Number   In order   In ord |
| a SEPARATA, in order of                     | What prophylactic was used to prevent Ophthalmia Neonatorum?  Number of child of this mother, including present birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| NG INK—T<br>I at birth a<br>or of each,     | FULL Orviel Milloy Bell MAIDEN Delaris China Hoff                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| UNEADING one child the number               | lt non-resident, give place and State  Color or race  Age at last Birthday  (Years)  Birthday  (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| WITH ore than                               | Occupation (City and State or County)  Occupation Occup |
| PLAINLY case of me                          | I hereby certify that I attended the birth of this child, who was Stillborn at M. on the date above stated.  (Signature)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| WRITE<br>N. B.—In                           | *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.  Address  Filed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

HITTHE TO THE DEFARES OF STREET BLE LEVEL BERNENE 18 Married Manual Manual Comments Print Hexater on District No. the still born, substitute the said Stribusth for same of child) Data of Legitie Julid: What prophylacil was used to process Obshalania Semutarun? tal Born salve and new tres Exchanger of child of this mather including present bath. lines win and wells man! Pendemotion places the contraction if non-received, mre plees and Mass. A STERNATOR OF DEAL PROPERTY OF STATE O TALL MOST TO TOTAL . Birmplata (Cly and appear Lounty) Crimmit to state with 113 editera.co delicographion ...... PARTYLINE TO RAPHRYRY LIMITORY THE STRUCTURES. a city in the I handly couldy time I attended the hiethers this child, who was hidden in the idea above stated. fall furle that earns no attending blivelenn tallington to ostoberalli or midwice, then the lather, house volder, de should nucke little return. A sintingen and addition to the method to be being divide after evidence of the nitter bieth

DIVISION OF VITAL STATISTICS

## DEPARTMENT OF COMMERCE BUREAU OF VITAL STATISTICS

C.K. MACEY SPECIAL AGENT

Boise, Idaho

180877

Mrs. 0.M. Bell Rexburg

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

| PLACE OF Rexburg         | DATE OF BIRTH                       | April 1    | 1, 1930         | SEX OF<br>CHILD | Fema. |
|--------------------------|-------------------------------------|------------|-----------------|-----------------|-------|
|                          | en born to this moth and now living | er, incl   | luding present  | birth           | 4     |
| 3. Born alive but no     | ov dead on                          | <u> </u>   |                 |                 |       |
| 4. Number of children    | en stillborn tu                     | <u> </u>   |                 |                 |       |
|                          | (Please write                       | plainly)   | 1               |                 | €.    |
| Information with INTHER  | n reference to                      | In         | nformation with |                 | e to  |
| Orville Mi               | lton Bed                            | De         | lous an         | cn name)        |       |
| 373 / 7, 4<br>(Residence |                                     | <u>a</u> 7 | (Resid          | HW.             |       |
| Age at last birthday     | 0/                                  | Ape at     | last birthda    | y 28            |       |
| Keshurg<br>(Birthpl      | ace)                                | _Z         | long            | Maluthplace)    | ٠ ل   |
| -Mala                    |                                     |            |                 |                 |       |

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

O.K. Maney

Special Agent, Bureau of the Census.

| 2.                                                             | RECEIVED MAY 1 6 193                                                  | STATE OF IDAH                    | ю 🏏 он                                  |                                              |                                         |
|----------------------------------------------------------------|-----------------------------------------------------------------------|----------------------------------|-----------------------------------------|----------------------------------------------|-----------------------------------------|
| PHYSICIANS<br>t of OCCUPA-                                     | RECEIVED MAIL TO 100                                                  | DEPARTMENT OF PUBLIC             | CWELFARE                                | DO NOT WRITE IN                              | THIS SPACE                              |
| <b>5</b> 5 4                                                   | PLACE OF DEATH                                                        | BUREAU OF VITAL ST.              | ATISTICS                                | , , , , , , , , , , , , , , , , , , , ,      | 70201                                   |
| 182<br>OC                                                      | County of madison                                                     | CERTIFICATE OF I                 | DEATH.                                  | State File No                                | <u> </u>                                |
| H J                                                            | County of                                                             | Registration District No         | 100                                     |                                              | , -                                     |
|                                                                | City of Cechning                                                      | Primary Registration District    |                                         | Local Registrar's                            | No.                                     |
| Y,                                                             | <i>*</i>                                                              | Filmary Registration District    | None                                    |                                              |                                         |
| ORD<br>ACTLY, 1<br>statement                                   | (If death occurred                                                    | (No                              | name instead of street and              | i number.)                                   | - 10                                    |
| ECORD<br>EXACTLY,<br>ict statemen                              |                                                                       | BRCC.                            |                                         |                                              | a OV                                    |
| RECORD<br>d EXACT<br>Exact state                               | 2. FULL NAME A CALLY                                                  |                                  | *************************************** | * **                                         |                                         |
| <b>75</b> .23                                                  | (a) Residence. No                                                     | hary.                            | St                                      | (If nonresident give city or                 | town and State)                         |
| at E                                                           | (Usual place of abode)  Length of residence in city or town where dea | th octobred. yrs. mos. ds.       | How long in U. S., if                   | of foreign birth! yrs.                       | mos. ds.                                |
| NG PERMANENT hould be state y classified. F                    | PERSONAL AND STATISTICA                                               | L PARTICULARS                    | MEDIC                                   | AL CERTIFICATE OF DE                         | ATH                                     |
| G<br>ERMAN<br>uld be<br>classifio                              | 8. SEX 4. COLOR OR RACE                                               | 5. Single, Married, Widowed,     | 16. DATE OF DEAT                        | TH O 1 CL                                    | .0.                                     |
| NG PERI hould y clar                                           | Donal white                                                           | or Divorced (write the word)     | Do                                      | in west ap                                   | nt// 1830                               |
| N Part                                                         | 5a. If married, widowed, or divorced                                  | 1                                |                                         | (Month) (Day)                                | (Year)                                  |
| BINDIN<br>IS A P<br>AGE she<br>properly                        | HUSBAND of<br>(or) WIFE of                                            |                                  | 17. I HEREBY CER                        | TIFY, That I attended decease                | ed from                                 |
|                                                                |                                                                       |                                  | april.                                  | /, to                                        | 19.20                                   |
| FOR<br>THIS<br>ed. ,                                           | 6. DATE OF BIRTH (month, day and year)                                | 74 X 7700 Alam 1 day             | that I hast saw h                       | alive on.                                    | - 19 - 19 - 19 - 19 - 19 - 19 - 19 - 19 |
| ID FC<br>TTE<br>pplied.<br>may                                 | 7. AGE Years Months                                                   | Days If LESS than 1 day, hrs. or |                                         | ed, on the date stated above,                | at 1007 recomi                          |
| SERVED I<br>G INK—1<br>Iy supplie<br>hat it may<br>certificate | sulf your                                                             | min.                             | The CAUSE OF DEA                        | TH* was follows:                             | , r                                     |
| RVE<br>INK<br>Sup<br>sup                                       | 8. OCCUPATION OF DECEASED                                             |                                  | 7//                                     | Trace de hold                                |                                         |
| SER<br>NG<br>Illy<br>that                                      | (a) Trade, profession, or particular kind of work                     |                                  | - Ago                                   | or opening                                   |                                         |
| <b>88.2 9</b> 1                                                | (b) General nature of industry,                                       |                                  |                                         | *                                            |                                         |
|                                                                | business, or establishment in which employed (or employer)            |                                  | 11. 12. 12. 12. 12. 12. 12. 12. 12. 12. | yrs.                                         | , mosds.                                |
| RGIN<br>UNFA<br>be car<br>erms, a                              | (c) Name of employer                                                  |                                  | CONTRIBUTORY                            |                                              |                                         |
| <b>→</b> ~ ~ ~                                                 | (c) Name of Employer                                                  |                                  |                                         | (duration)yrs.                               | mos. ds.                                |
| MA<br>VITH<br>hould<br>plain<br>tion o                         | 9. BIRTHPLACE (city or town)                                          | hung                             | 18. Where was diseas                    |                                              |                                         |
| M<br>NLY, WITH<br>tion shoul<br>IH in plain<br>instruction     | (State or country)                                                    | <del></del>                      | if not at place of                      | death?                                       |                                         |
| string K                                                       | 10. NAME OF FATHER                                                    | 00                               | Did an operation prec                   | ede death? Date of                           | 77                                      |
| H 80 H                                                         | - Car De                                                              |                                  | Was there an autops;                    | 11121                                        |                                         |
| PLAI<br>oform<br>DEA'<br>See                                   | 11. BIRTHPLACE OF FATHER (city or (State or Country)                  | town)                            | What test confirmed                     | liagnosis                                    | - July                                  |
| · 🛏                                                            | (State or Country) Of Les                                             | godaho                           | (Signed)                                | 30                                           | , м. р.                                 |
| WRITE<br>item of ii<br>AUSE OF                                 | 2 12. MAIDEN NAME OF MOTHER                                           |                                  | - Fax /2, 18                            | (Address)                                    | org                                     |
| R.F.                                                           | Delones Ha                                                            | ug - och                         | *State the DISEAS                       | E CAUSING DEATH, or in d                     | leaths from VIOLENT                     |
| W]                                                             | 13. BIRTHPLACE OF MOTHER (city of (State or Country)                  | pf selon racko                   | 'l→ CAUSES, state (1)                   | MEANS AND NATURE OF AL, SUICIDAL, OF HOMICIE | F INJURY, and (2)                       |
| 7.5                                                            | 0.00                                                                  |                                  |                                         | Cremation, or Removal                        | Date of Burial                          |
| very<br>te (                                                   | 14. Informant Coal Isel                                               |                                  | To. I moo or During,                    | Ozdinavion, Oz Memovai                       | 102                                     |
|                                                                | (Address) Replaced                                                    | Selaha                           | Vetonber                                | nelary                                       | 100 10                                  |
| NE'S                                                           | 15.                                                                   | De Per amore                     | 20. Undertaker                          | - 11 N                                       | Address.                                |
| 10.                                                            | Filed , 1980.                                                         | Registrat                        | 6676                                    | cherrello                                    | Highe.                                  |
| A 20 E                                                         | []                                                                    |                                  | -                                       |                                              | 0 0/                                    |

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spinal fever (the only definite synonym is "Epidemic

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struck by railway train-accident; Revolver wound of

head-homicide; Poisoned by carbolic acid-probably sui-

cide. The nature of the injury, as fractured skull, and con-

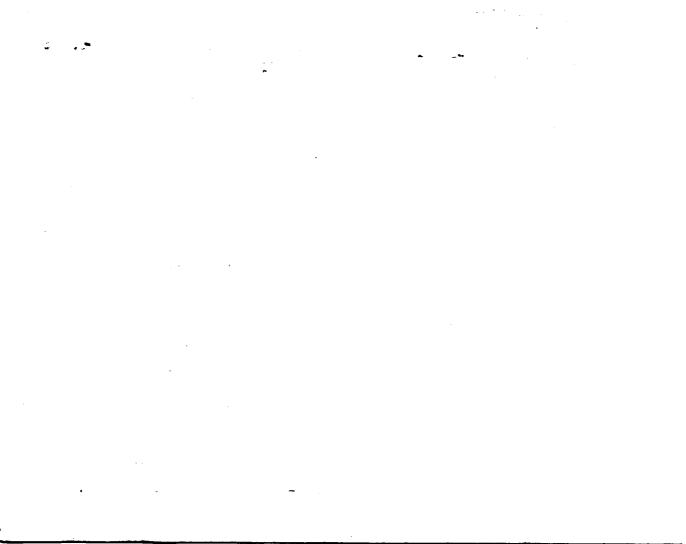
sequences (e. g. sepsis, tetanus) may be stated under the

Do not accept a certificate of death signed only by a

midwife.

head of "Contributory."

| 7 ( 2 1 / 1                                                                                                                                                                                          | to the                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| PLACE PLACE TERTH JUN 5 1930 D                                                                                                                                                                       | STATE OF IDAHO EPARTMENT OF PUBLIC WELFARE                                  |
| County ofAda                                                                                                                                                                                         | BUREAU OF VITAL STATISTICS                                                  |
|                                                                                                                                                                                                      | CERTIFICATE OF BIRTH 180981                                                 |
| City of Boise                                                                                                                                                                                        | 9                                                                           |
| No. St. Registration District                                                                                                                                                                        | No. File No.                                                                |
| Hospital St. Luke's Primary Registration                                                                                                                                                             |                                                                             |
| FULL NAME OF CHILD Donald DeVere                                                                                                                                                                     | Korup ficate of no value without full name of child.)                       |
| Sex of Child  Twin Triplet X and Sin order X of birth To be answered only in event of plural by                                                                                                      | Legiti- mate? yes  Date day 12 birth 12 (Month) (Day) (Year)                |
|                                                                                                                                                                                                      |                                                                             |
| Number of child of this mother, including present birth Nu                                                                                                                                           | umber of child of this mother now living, including present birth2          |
| FULL FATHER NAME Fred D. Korup                                                                                                                                                                       | FULL MOTHER MAIDEN NAME AUdrey L. Liddle                                    |
| RESIDENCE Boise                                                                                                                                                                                      | RESIDENCE BOISE                                                             |
| COLOR Wnite AGE AT LAST BIRTHDAY (Years)                                                                                                                                                             | COLOR AGE AT LAST 23 BIRTHDAY(Years)                                        |
| BIRTHPLACE Idake                                                                                                                                                                                     | BIRTHPLACE Utah                                                             |
| OCCUPATION Butcher                                                                                                                                                                                   | OCCUPATION HOUSE-Wife                                                       |
| CERTIFICATE OF ATTENDI  I hereby certify that I attended the birth of this child, who en the date above stated.                                                                                      | NG PHYSICIAN OR MIDWIFE*  was Stillborn 5.30 8 M  (Born alive or stillborn) |
| *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence. (Signature) | Physician                                                                   |
| (dence of life after birth.                                                                                                                                                                          | (Physician or midwife)                                                      |
| Give names added from a supplemental report.  Address:                                                                                                                                               | 202-203 Robert Noble Bldg. Boise                                            |
| Filed C                                                                                                                                                                                              | 5-16 1930 W.M. Modes                                                        |



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PLACE PHOPPH'ED HIN 9 1930 STATE OF IDAHO RECORD rust be ma DEPARTMENT OF PUBLIC WELFARE County of Busham BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH PERMANENT RECEEDED TO SERVICE TO Registration District No. 12 .....State File No..... (If born in hospital or institution Prim. Registration District No.2.1.9.4.ocal Registrar's No.4 give name) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of shild) Number Twin Date of Legiti-Sex of \_ Triplet in order birth ... mate? or other? Child (To be answered only in event of plural births) (Month) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead Stillborn FATHER FULL MAIDEN Residence (Usual place of abode Residence (Usual place of abode) If non-resident, give place and State It non-resident, give place and State Color or race. Age at last Birthday..... Color or race.......Age at last Birthday..... Birthplace (City and State or County) Birthplace (City and State or County) Occupation .... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Registrar.

**Maria** de la compansión de la compansió and the second APPLY CO-DISTRIBUTE MATERIAL CONTRACTOR Registration where the Land Court The Man Prior inches Miles Vols / Land Bernard Registrates No. the filler of channe and west sufficient of the filler ALTER OF CHILD rodate i Ecultinorth The Parish of the business of the business mate (a) not) what property was that to make the Cubtoning Monntowns Tuntion of will a state specific specific second with the state of the Stillborn. bank won Hist syrin Brotte the state of the s H orace where, the play and the many The property of the state of th The same and the same all the same Course of the party of the party of the party .... donigateuti ... (chip and State or County) CHANGE OF COURTS and the second nothing to the THE TOWNS OF TALESTONE SAINTS ON WINDS ON THE SECOND I house course thirty agreeted the their or the child, who wast south the this date shore water. ruringuist White the entangement and the solutions and wife that the faller householder. crothing a sense the reason at the boots child is one that netter from at blide All the street of the manufacture and to ever

STATE OF IDAHO 1830 DEPARTMENT OF PUBLIC WELFARE PERLEULU JUN 9 PHYSICIAL

OCCUI DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No..... County of Burne Registration District No..... Local Registrar's No... Primary Registration District No. (If death occurred in a hospital or institution, give its name instead of street and number.) A PERMANENT RECORD 2. FULL NAME. (a) Residence. No. St. St. (If nonresident give city or town and State) (Usual place of abode) How long in U. S., if of foreign birth? Length of residence in city or town where death occurred. mos. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS Single, Married, Widowed, DATE OF DEATH 8. SEX 4. COLOR OR RACE plnous or Divorced (write the word) (Day) 5a. If married, widowed, or divorced That I attended HUSBAND of (or) WIFE of 6. DATE OF BIRTH (month, day and year) 7. AGE Years Months and that death occurred, on the date stated above, at CAUSE OF DEATH\* was #9 follows: min. 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in (duration) \_\_\_\_yrs. \_\_\_ which employed (or employer) CONTRIBUTORY (c) Name of employer (Secondary) (duration) .....yrs. BIRTHPLACE (city or 18. Where was disease contracted (State or country) if not at place of death? NAME OF FATHER Did an operation precede death? Was there an autopsy 11. BIRTHPLACE OF FATHER (city or town) What test confirmed flia (State or Country) (Signed). \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Place of Burial, Cremation, or Removal Date of Burial Informan (Addres 13.

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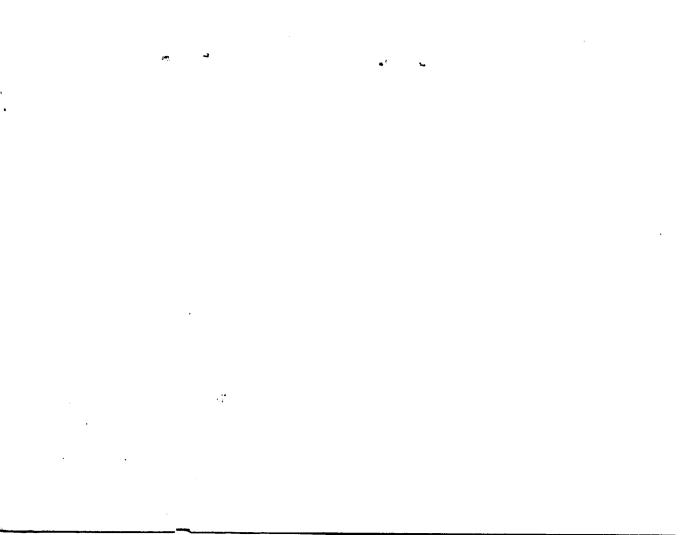
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RECORD be made for OHACT TO STATS PUBLIC WELFARE BUREAU OF VITAL STATISTICS OF BIRTH PERMANNENT I RETURN must be the stated. State File No. Registration District No. (If born in hospital or institution Prim. Registration District No. 100 Local Registrar's No give name.) FULL NAME OF CHI (If stillborn, substitute the word "Stillbirth" for name of child) Number Date of Sex of Legiti-Triplet in order hirth or other? Child mate \ \ (To be answered only in event of plural births (Mont) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? (a) Born alive and now living Number of child of this mother, including present birth. Stillborn.... Born alive but now dead. MOTHER FULL FIILL. Residence (Usual place of abode) Residence (Usual place of abode)... If nonresident, give place and State If nonresident, give place and State. Age at last Birthday. Age at last Birthday Birthplace Birthplace (City and State or Country) (City and State or Country) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE® more Born slive I hereby certify that I attended the birth of this child, who was { Stillborn PLAINLY on the date above stated. ö (Signature) case \*Where there was no attending physician (Physician WRITE B—In or midwife, then the father, householder, etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth.



STATE OF IDAHO RECEIVED JUN 9 DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No..... Registration District No.. Local Registrar's No. Exact statement Primary Registration District No. 0.17 in a hospital or institution, give its name instead of street and number.) 2. FULL NAME. (a) Residence. No. St. (Usual place of abode) (If nonresident give city or town and State) Length of residence in city or town where death occurred. How long in U. S., if of foreign birth? yrs. mos. mos. PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH 16. DATE OF DEATH 3. SEX COLOR OR RACE 5. Single, Married, Widowed, hould 5a. If married, widowed, or divorced HUSBAND of I HEREBY CERTIFY, That I attended deceased from (or) WIFE of 6. DATE OF BIRTH (month, day and year) 7. AGE and that death occurred, on the date stated above, at..... The CAUSE OF DEATH\* was as follows: min. 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry. business, or establishment in which employed (or employer) CONTRIBUTORY (c) Name of employer (Secondary) (duration) \_\_\_\_\_yrs, \_\_\_mos, \_\_\_\_ 9. BIRTHPLACE (city or tov 18. Where was disease contracted (State or country) if not at place of death? 10. NAME OF FATHER Did an operation precede death? .... Date of...... Was there an autopsy? 11. BIRTHPLACE OF FATHER What test confirmed diagnosis (State or Country) \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE OF MOTHER (city or town (State or Country) Date of Burial Informant (Address) Addre Registrar

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
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DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

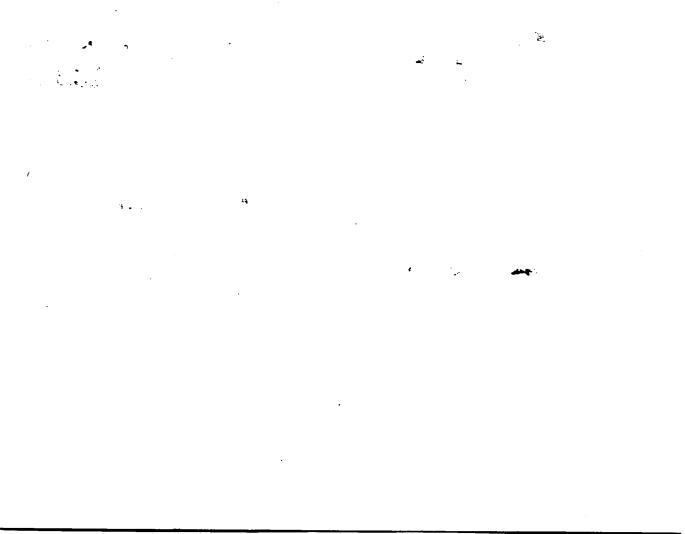
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head of "Contributory."

Do not accept a certificate of death signed only by a midwife.

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STATE OF IDAHO RECORD be made for DEPARTMENT OF PUBLIC WELFARE County of .. BUREAU OF VITAL STATISTICS 2 CERTIFICATE OF BIRTH No. Registration District No. / 3/ State File No .... (If born in hospital or institution Prim. Registration District No. 194 Local Registrar's No. 3 give name.) FULL NAME OF CHILD...... (If stillborn, substitute the word "Stillbirth" for name of child) Number Date of Legiti-Sex of Triplet in order Child M or other? of hirth mate? (Month) (To be answered only in event of plural births) What prophylactic was used to prevent Ophthalmia Neonatorum? 18 70 20 \_\_\_\_ (a) Born alive and now living. Number of child of this mother, including present birth\_ Stillborn Born alive but now dead. MOTHER FULL MAIDEN Residence (Usual place of abode). Residence (Usual place of abode) ... If nonresident, give place, and State If nonresident, give place and State.... Age at last Birthday 26 Age at last Birthday 25 Color or race Color or race (Years) Birthplace \_ Birthplace (City and State or Country) (City and State or Country) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. PLAINLY case of mor I hereby certify that I attended the birth of this child, who was \ Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Registrar.



FORM V. S. No. 5-25 M. 1-19. of certificate. CERTIFICATE OF DEATH State of Idaho BOARD OF HEALTH Radiation District No. Bureau of Vital Statistics County of Primary Registration District No... CAUSE of Registered No. If death occurred in a hos-If death occurs away from pital, institution or camp, give its NAME instead of usual residence, give facts called for under special instreet and number. formation. 2. FULL NAME. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 4. COLOR OR RACE | 5. SINGLE. MARRIED. WID-3. SEX OWED OR DIVORCED r, PHYSICIANS important. See is 16. DATE OF DEATH 30 PERMANENT 6. DATE OF BIRTH (Month) (Day) (Year) I HEREBY CERTIFY. That I attended deceased from EXACTLY, (Month) (Day) (Year) IF LESS than 1 day 7. AGE low many ...min.? and that death occurred on the date stated above, at..... 8. OCCUPATION (a) Trade, profession or particular kind of work..... (b) General nature of industry, business or estab-lishment in which employed (or employer)..... 9. BIRTHPLACE Contributory (State or Country (Secondary) 10. NAME OF FATHER (Signed).. 1. BIRTHPLACE OF FATHER (State or Country) \*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Salcidal or Homicidal. 12. MAIDEN NAME OF MOTHER 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) 13. BIRTHPLACE OF MOTHER In the At place of death... (State or Country) Where was disease contracted BEST OF MY KNOWLEDGE 14. THE ABOVE if not at place of death?..... Former or (Informant) usual residence ..... (Address)... REMOVAL 15. B.—E ADDRESS 20. UNDERTAT Local Registrar SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Though the child had been that the child had been the child head here was not in perfect head to be the child the child head to be the child the child be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

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accepted term for the same disease. Examples: Cerebrococcupation is very important, so that the relative health—

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Print. Registration insider the Local Recommendation THE THE PERSON IN THE PERSON I the in agreement and the moral will be the confirmed and the confi Where continued was used to prevent Ophilairals Scomplering? light alive but now dead a L. Com-HYPETAS teatist south ..... Personal Completeres and the Marine With the House House Ocoupeties ..... o state on the CHUNELAND OF ATTENDING PRESENTAN OF ADMINISTRA Charely cently that I artroded the birth of this child, who was in the late above stated, (Signatura) Call the to their was no attending physician Personal residence to will parte. Then the lacine . homestinger, and the property of the last o the one time wellor invating and the series of the series of the series

| r RECORD<br>ed EXACTLY, PHYSICIANS<br>Exact statement of OCCUPA-                                                                                          | PLACE OF DEATH  County of Bonne ville  City of Idaho Falls, Idaho  (If death occurred in a hospital or institution, give its  Ca) Residence. No                                      | DEATH  Comparison of the compa |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ANEN'<br>be stat<br>sified.                                                                                                                               | Length of residence in city or town where death occurred. yrs. mos. ds.  PERSONAL AND STATISTICAL PARTICULARS                                                                        | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| BINDING<br>IS A PERMANENT<br>AGE should be stated<br>properly classified. E                                                                               | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)  5a. If married, widowed, or divorced HUSBAND of                                                   | 16. DATE OF DEATH  April 3, 19 30  (Month) (Day) (Year)  17. I HEREBY CERTIFY, That I attended deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| WRITE PLAINLY, WITH UNFADING INK—THIS IS A P item of information should be carefully supplied. AGE she important. See instruction on back of certificate. | 6. DATE OF BIRTH (month, day and year) April 3, 1930  7. AGE Years Months Days If LESS than 1 day, Stillborn hrs. or  8. OCCUPATION OF DECEASED  (a) Trade, profession, or           | April 3 , 1930 , to April 3 , 1930 that I last saw h er slead April 3 , 1930 and that death occurred, on the date stated above, at 2:00 m.  The CAUSE OF DEATH* was as follows: Asphixiation due to premature separation of placenta in utero  (duration) yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                           | 9. BIRTHPLACE (city or town) Idaho Falls, Idaho (State or country) I.D.S. Hospital  10. NAME OF FATHER                                                                               | CONTRIBUTORY Premature 8 Months (Secondary)  (duration) yrs. mos. ds.  18. Where was disease contracted Rigby R#2  Did an operation precede death? No Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                           | William James Barnes  11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho Falls, Idaho  12. MAIDEN NAME OF MOTHER Thora Newman  13. BIRTHPLACE OF MOTHER (city or town) | Was there an autoper Casarian Section  What test confirmed diagnoss?  (Signed)  April 4, 1280 (Address) Idaho Falls  *State the DESASE CAUSING DEATH, or in deaths from VIOLENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 15/158 + N<br>H. B.—Every iter<br>hould state CAUI                                                                                                        | (State or Country) Milo, Idaho  14. Informant Mrs. William James Barnes (Address) Righy Rw2  15. Filed By 7 1934                                                                     | *State the DISPASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  19. Place of Burial, Cremation, or Removal Date of Burial Cremation at L. S. S. 20. Undertaker HOS pital Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| - <u>- 25</u>                                                                                                                                             | Registrar                                                                                                                                                                            | Zider                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

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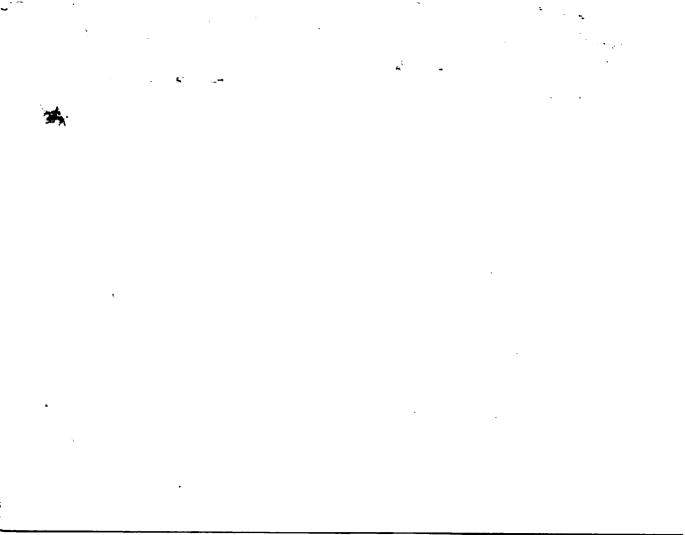
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Do not accept a certificate of death signed only by a midwife.



STATE OF IDAHO MAY 2 4 1930 DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No. Registration District No..... Local Registrar's No... Exact statement Primary Registration District No.... (No. in a hospital or institution, give its name instead of street and number.) 2. FULL NAME. (a) Residence. No.... (If nonresident give city or town and State) (Usual place of abode) How long in U. S., if of foreign birth? Length of residence in city or town where death occurred. YIE. mos classified. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 5. Single, Married, Widowed, or Divorced (write the word) 16. DATE OF DEATH 8. SEX 4. COLOR OR RACE (Mont (Day) 5a. If married, widowed, or divorced HUSBAND of 17. I HEREBY CERTIFY That I attended deceased (or) WIFE of 6. DATE OF BIRTH (month, day and year) 7. AGE Months If LESS than 1 day, Days hat it may certificate. and that death occurred, on the date stated above The CAUSE OF DEATH\* was as follows: 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry. ...(duration) \_\_\_\_\_yrs. \_\_\_mos. business, or establishment in which employed (or employer) CONTRIBUTORY ..... (c) Name of employer (Secondary) (duration) \_\_\_\_\_yrs, \_\_\_\_mos. \_\_ plnous BIRTHPLACE (city or town 18. Where was disease contracted (State or country) if not at place of death? To Date of Did an operation precede death?... Was there an autopsy? 11. BIRTHPLACE What test confirmed diagnesis (State or Countr (Signed) \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE OF MOTHER (State or Country) Place of Burial, Cremation, or Removal Date of Burial Informant (Address) Address Undertaker Registrar

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| PLACEREGISTAL MAY 2 4 1930                                                           | STATE OF IDAHO                                        |  |
|--------------------------------------------------------------------------------------|-------------------------------------------------------|--|
| County of Samuelle                                                                   | DEPARTMENT OF PUBLIC WELFARE                          |  |
| city of Jacks Falls                                                                  | BUREAU OF VITAL STATISTICS 10118                      |  |
| 355-105010-391 st                                                                    | CERTIFICATE OF BIRTH                                  |  |
| J. S. Waspital Registration I                                                        | District No. 23                                       |  |
| If born in hospital or/institution                                                   | 2 1-1-0                                               |  |
| in manory                                                                            | tion District No. Local Registrar's No. 134           |  |
| FULL NAME OF CHILD(If stillborn.                                                     | , substitute the word "Stillbirth" for name of shild) |  |
| Twin Number                                                                          |                                                       |  |
| Sex of Triplet and in order of birth                                                 | Legiti- mate? 46 birth April 5 1932                   |  |
| (To be answered only in event of plural bi                                           | (Month) (Day) (Year)                                  |  |
| What prophylactic was used to prevent Ophthalm                                       | ia Neonatorum? Marce                                  |  |
| Number of child of this mother, including present birth                              |                                                       |  |
| Born alive but now dead2                                                             | Stillborn                                             |  |
| FATHER                                                                               | FULL / MOTHER                                         |  |
| NAME Oren Ward Lee                                                                   | MAIDEN Lydia Trauels Tracy.                           |  |
| Residence (Usual place of abode) Lagonal Idahu                                       | Residence (Usus) place of abode ' Classory            |  |
| t non-resident, give place and State                                                 | If non-recident, give place and State                 |  |
| Color or race White Age at last Birthday 4/                                          | Color or race White Age at last Birthday 39           |  |
| Birthplace Milo Idaho (Year                                                          | Birthplace agalw Mah                                  |  |
| (City and State or County) Occupation + axamet                                       | Occupation Occupation                                 |  |
|                                                                                      | DING PHYSICIAN OR MIDWIFE*                            |  |
| CENTIFICATE OF ATTENT                                                                | ( Boss-alive )                                        |  |
| I hereby certify that I attended the birth of th                                     | is child, who was Stillborn at 4.25 A.M.              |  |
| on the date above stated.                                                            | DINI DO                                               |  |
|                                                                                      | (Signature)                                           |  |
| *Where there was no attending physician                                              | Physician et Surgeon                                  |  |
| or midwife, then the father, householder, etc., should make this return. A stillborn | (Physician or midwife)                                |  |
| child is one that neither breathes nor                                               | Address Sallo Faho.                                   |  |
| shows other evidence of life after birth.                                            | File Chan 9 1930 alterna                              |  |
| •                                                                                    | Registrar                                             |  |

BLACK THE TO AS STATE PERSONAL PARTY THE SECTION OF THE STATISTICS THE PERSON Horiston Butter Ma William Transfer The de deal of the state of the Samme. to die de side de CAST THOMAS Tabent to the second of the se What involudated was used to prepaid Ophthaling Noonatorum? Munera at child of this morning including growns with the book allow and on them. ... arodliud. tiding allow but now dead MORN EX WELLY W PATRICIA The state of the s CAMP .... Market .... the rice Lindbly and shock and and South or Wood other Water to see the second of the second H. mar afred, give played their British British Silve Dictor Series Color of man and an army the state and Company to the state of the sta Birthplace of he and steel or county. A PRINCIPLE OF A NAME OF A STATE OF THE PARTY thorepotion . ANCHORISM . ELECTRICAL OF ATTEMPTOR PHYSICIAN OF ATEMPTICAL I hereby ee ur that I attended the bieft of the chitd, where was "the horn fat the the three store states. "Whe chacte was no attending procession Later of the set of the cartes of inhivity, then the father bruise balder. A TOUR AND A STREET AND STREET PLOOP. STR this is not the medical prestates nor street 1911a gift 10 companies really evolutions 

| ENT RECORD stated EXACTLY, PHYSICIANS d. Exact statement of OCCUPA-        | PLACE OF DEATH  County of State Of IDAI  City of Samuelle  (If death occurred in a hospital or institution, give its                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | C WELFARE ATISTICS DEATH  State File No  Local Registrar's No                                                        |
|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                            | (a) Residence, No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | St.  (If nonresident give city or town and State)  How long in U. S., if of foreign birth? yrs. mos. ds.                                                                                                                                                 |
| BINDING<br>IS A PERMANENT<br>AGE should be state<br>properly classified. H | PERSONAL AND STATISTICAL PARTICULARS  8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)  5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH    10                                                                                                                                                                                                    |
| ERVED FOR G INK—THIS y supplied tat it may be certificate.                 | 6. DATE OF BIRTH (month, day and year)  7. AGE Years Months Days If LESS than 1 day, hrs. or min.  8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | that I last saw h. alive on 19 and that death occurred, on the date stated above, at m.  The CAUSE OF DEATH* was as follows:                                                                                                                             |
| MARGIN RES<br>ITH UNFADIN<br>ould be carefull<br>lain terms, so th         | (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (duration) yrs. pos. ds.  CONTRIBUTORY (Secondary)  (duration) yrs. mos. ds.                                                                                                                                                                             |
| PLAINLY, W<br>nformation sh<br>DEATH in p<br>See instruct                  | (State or country)  10. NAME OF FATHER  OLINI (CLUMB Lee  11. BIRTHPLACE OF FATHER (city or town)  (State or Country)  The Country of the Cou | 18. Where was disease contracted if not at place of death?  Did an operation precede death?  Date of  Was there an autopsy?  What test confirmed diagnosis?  (Signed)                                                                                    |
| WRITE WRITE —Every item of i state CAUSE OF is very important.             | 12. MAIDEN NAME OF MOTHER  18. BIRTHPIACE OF MOTHER (elty or town) (State on/Country)  14.  Informant  (Address)  Olshir Fael, R & D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  19. Place of Burial, Cremation, or Removal  Date of Burial  Lals  20. Undertaker  Address |
| / & /<br>N. B.<br>Should<br>TION                                           | 15. Piter 17. V , 19.3.7 Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | - come                                                                                                                                                                                                                                                   |

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| RETURN must be made for<br>h stated.          | City of Caldwell St. Caldwell Sanitarium Registration Dist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                |  |  |
|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|--|
| RETURN m<br>th stated.                        | FULL NAME OF CHILD Stillogram.  (If stillborn, subsection of the still | bstitute the word "Stillbirth" for name of child)    Legiti-   Date of 5/12/30                 |  |  |
| SEPARATE RI                                   | Child Girl or other? ) (of birth mate?Yes Dirth (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |  |  |
| birth a<br>each, in                           | Born alive but now dead  FATHER  FULL F. E. Marchek  NAME Harper, Oregon  Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Stillborn  FULL MOTHER MAIDEN Beatrice Stage NAME Harper Oregon Residence Usual Place of abode |  |  |
| ne child at<br>number of                      | If nonresident, give place and State  Thite  Color or race  Youring  (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | If nonresident, give place and State  Color or race  Thite  Age at last Birthday  (Years)      |  |  |
| han or                                        | Birthplace   (City and State or Country)   Occupation   Carrier Ing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | City and State or Country)   Occupation                                                        |  |  |
| of more than one child<br>each and the number | CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*    Lange   Lang |                                                                                                |  |  |
| N. B.—In case                                 | or midwife, then the father, householder, etc., should make this return. A stillborn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Caldwell, Idaho  5-15-19.30 John & Meyes                                                       |  |  |
| 4                                             | d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Registf                                                                                        |  |  |

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| PHYSICIAN                                                                                        |                                                                                                                                                                                                                    | DO NOT WRITE IN THIS SPACE State File No. () 5 ! ')  No. 2005 Local Registrar's No. 52                                                                                         |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| stated EXACTLY. operly classified. ructions on back.                                             | (No.  (If death occurred in a hospital or institution, give  2. FULL NAME Baby Marchek  (a) Residence. No.  (Usual place of abode.)  Length of residence in city or town where death occured. yrs. mos.            | St.  (If nonresident give city or town and State.)  ds. How long in U. S. if of foreign birth? yrs. mos. ds.                                                                   |
| RVED FOR BINDING supplied. AGE should be terms, so that it may be pr is very important. See inst | PERSONAL AND STATISTICAL PARTICULARS  3. SEX                                                                                                                                                                       | MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  May 19 19 19 19 19 19 19 19 19 19 19 19 19                                                                                    |
|                                                                                                  | 6. DATE OF BIRTH (month, day and year)  7. AGE Years Months Days If LESS than 1 day, hrs. or  O O                                                                                                                  | and that death occurred, on the date stated above, at                                                                                                                          |
| MARGIN JING INK—TH should be care OF DEATH in it of OCCUPAL                                      | (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer  9. BIRTHPLACE (city or town) Caldwell (State or country) Idaho  10. NAME OF FATHER Frank Marchek | (duration) yrs. mos. ds.  CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.                                                                                                    |
| INLY, WITH UNFAI<br>item of information<br>should state CAUSE<br>Exact statemen                  | 11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wyoming  12. MAIDEN NAME OF MOTHER Beatrice Stage  13. BIRTHPLACE OF MOTHER (city or town) (State or County)                                            | 18. Where was disease contracted if not at place of death?  Did an operation precede death?  Was there an autopsy?  What test confirmed diagnosis?  (Signed)  (1930) (Address) |
| 19 1209 + WRITE PLAINLN N. B.—Every item shou                                                    | 14. Informant (Address) Frank Marchek Harper Oregon  15. Filed 5 13 -, 1930 Pohn St Meyes - Registrar.                                                                                                             | 19. Place of Burial, Cremation, or Removal  Canyon Hill 20. Undertaker  Paul L. Case  Caldwell, Id                                                                             |

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RECEIVED JUN 1 0 1930 STATE OF IDAHO PHYSICIAN of OCCUPA DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH State File No. 70500 CERTIFICATE OF DEATH County of Canyon Registration District No..... City of Nampa Local Registrar's No .. Primary Registration District No. 1006 stated EXACTLY. A PERMANENT RECORD Inf. daughter of Mr and Mrs. Earl Brounfield 2. FULL NAME... 1605-3 st. No. (a) Residence, No.... (If nonresident give city or town and State) (Usual place of abode) How long in U. S., if of foreign birth? Length of residence in city or town where death occurred. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 16. DATE OF DEATH 5. Single, Married, Widowed, or Divorced (write the word) 8. SEX 4. COLOR OR RACE May 9, 1930 White Fem. (Day) (Year) Daughter of 5a. If married, widowed, or divorced attended deceased from HUSBAND of Mr. and Mrs. Brownfield (or) WIFE of 6. DATE OF BIRTH (month, day and year) May 9. 1930 If LESS than 1 day, 7. AGE Years Months Days and that death occurred, on the date stated The CAUSE OF DEATH\* 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... None (b) General nature of industry. business, or establishment in which employed (or employer) terms. CONTRIBUTOR (c) Name of employer (Secondary) plain Nampa Ida. of information should OF DEATH in plain ant. See instruction 9. BIRTHPLACE (city or town) Where was disease contracted (State or country) if not at place of death? Did an operation precede death?..... Date of... 10. NAME OF FATHER Earl Brownfield Was there an autopsy? 11. BIRTHPLACE OF FATHER (city or town) Ill What test confirmed discr (State or Country) AUSE OF important. 12. MAIDEN NAME OF MOTHER COTA M. Roby \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE OF MOTHER (city or town) (State or Country) —Every i state C⁄ is very i 19. Place of Burial, Cremation, or Removal Date of Burial Earl Brownfield Informant. 19 Hohlerlawn 1605 3st No. (Address) 20. Undertaker Address Robinson File Ju ampa Ida. Registrar m.

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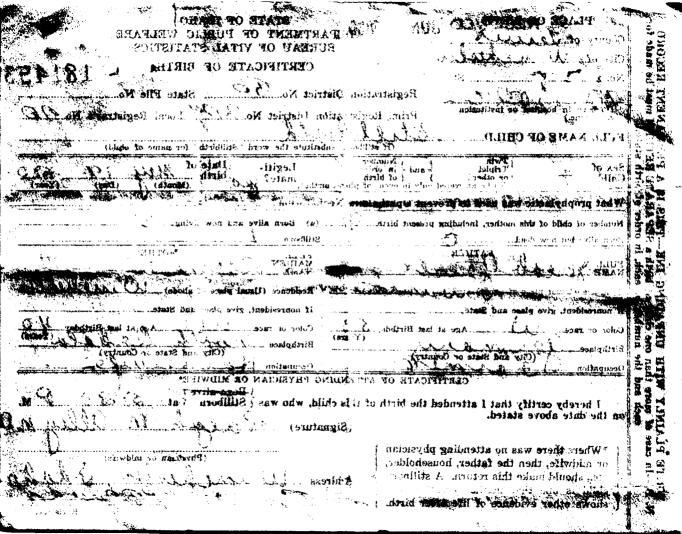
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Do not accept a certificate of death signed only by a midwife.

CRIN D JIIN 5 STATE OF IDAHO 1930 EPARTMENT OF PUBLIC WELFARE RECORD County of BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH 181453 must PERMANENT Registration District No. State File No. Prim. Registration District No. 2/2 Local Registrar's No. 20 give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Date of Sex of Legiti-Triplet in order birth Child or other? of birth mate? A A (To be answered only in event of plural births) (Month) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth... (a) Born alive and now living... Born alive but now dead. Stillborn MOTHER FULL birth each. MAIDEN NAME UNFADING one child at ble number of ea Residence (Usual place of abode Residence (Usual place of abode) If nonresident, give place and State. If nonregident, give place and State Color or race Age at last Birthday... (Years) Birthplace Birthplace. (City and State or Country) City and State or Country Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE PLAINLY W
case of more ( જ () I hereby certify that I attended the birth of this child, who was i Stillborn on the date above stated. \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Registrar.



| ILY, PHYSICIANS ement of OCCUPA-                                                                | RECEIVED JUN 5 PLACE OF DEATH County of City o | C WELFARE FATISTICS  DEATH  State File No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| BINDING IS A PERMANENT RECORD AGE should be stated EXACTLY, properly classified. Exact statemer | (No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | St. (15 nonrouldent give eiter en torre and Shata)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                 | PERSONAL AND STATISTICAL PARTICULARS  8. SEX 4. COLOR OR RACE or Divorced (write the word)  5a. If married, widowed, or divorced (Write the word)  6a. If married, widowed, or divorced (Write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  19. 19.3 O  (Month) (Day) (Year)  17. I HEREBY CERTIFY. That I attended deceased from the control of the co |
| RVED FOR INK—THIS supplied. t it may be rtificate.                                              | 6. DATE OF BIRTH (month, day and year) The 19 19 30  7. AGE Years Months Days If LESS than 1 day, hrs, or min.  8. OCCUPATION OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | that I last saw here alive on 19. 19. 19. 19. 19. 19. 19. 19. 19. 19.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ARGIN<br>UNFA<br>be car<br>terms, on back                                                       | (a) Trade, profession, or particular kind of work  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (duration) yrs. mos. de CONTRIBUTORY Shoulds Presentation Desprise (Secondary)  Allues (duration) yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| MLAINLY, WITH nformation should DEATH in plain See instruction                                  | 9. BIRTHPLACE (city or town)  10. NAME OF FATHER  11. BIRTHPLACE OF FATHER (city or town)  (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 18. Where was disease contracted if not at place of heath?  Did an operation precede death?  Was there an autopsy?  What test confirmed diagnosis?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| WRITE item of it. AUSE OF important.                                                            | 11. State or Country)  12. MAIDEN NAME OF MOTHER (city or town)  (State or Country)  18. BIRTHPLACE OF MOTHER (city or town) (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | *State the DISEASE CAUSING DEATH, or in deaths from VIÓLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| N. B.—Every<br>should state (<br>TION is very                                                   | 14. Informant and Garden Jacks  (Address) Unrheater, Idaho  15. Filed 33, 1890. Phone Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 19. Place of Burial, Cremation, or Removal  Date of Burial  19. Place of Burial  5/20 1950  20. Undertaker  Address  Where the state of Burial  Sylvential  Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

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PLACE BEGGEWED JUN 1 7 1930 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No. State File No. Primary Registration District No. 7 Local Registrar's No. (Certificate of no value without full name of child) Date of Way 40 Number Twin Legiti-Sex of in order Triplet mate! Ula Child or other? (Month) (To be answered only in event of plural births) What bactericidal solution was used in eyes!...... Number of child of this mother, including present birth. \_Number of child of this mother now living, including present birth\_ MOTHER FULL FULL MAIDEN NAME NAME RESIDENCE RESIDENCE AGE AT LAST COLOR COLOR BIRTHDAY. (Years) (Years) BIRTHPLACE BIRTHPLACE OCCUPATION OCCUPATION CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE+ WRITE PLAINLY I hereby certify that I attended the birth of this child, who was I Stillborn on the date above stated. \*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. ician or midwife Give names added from a supplemental report. Registrar.

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|-----------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------|------------------------------------------------------------------------------|
| RECEIVED JUN 1 7 1930                                                 | STATE OF IDA                                                       |                                            | 32.7. W                                                                      |
|                                                                       | DEPARTMENT OF PUBLIC<br>BUREAU OF VITAL ST                         |                                            | DO NOT WRITE IN THIS SPACE                                                   |
| PLACE OF DEATH                                                        | CERTIFICATE OF                                                     |                                            | State File No.                                                               |
| County of Nez Perce.                                                  | Registration District No                                           |                                            | 5440 2110 110                                                                |
| City of Lewiston.                                                     |                                                                    |                                            | Local Registrar's No                                                         |
| -                                                                     | Primary Registration District                                      |                                            | . 10                                                                         |
| (If death occur)                                                      | (No. St Joseph Hospi<br>red in a hospital or institution, give its | name instead of street and                 | number.)                                                                     |
| 2. FULL NAME Patricia                                                 |                                                                    |                                            | •                                                                            |
|                                                                       |                                                                    |                                            |                                                                              |
| (a) Residence. No(Usual place of abode)                               |                                                                    |                                            | (If nonresident give city or town and State) of foreign birth? yrs. mos. ds. |
| Length of residence in city or town where d                           | eath occurred. yrs. mos. as.                                       |                                            |                                                                              |
| PERSONAL AND STATISTI                                                 |                                                                    |                                            | AL CERTIFICATE OF DEATH                                                      |
| 8. SEX 4. COLOR OR RACI                                               | 5. Single, Married, Widowed,<br>or Divorced (write the word)       | 16. DATE OF DEAT                           |                                                                              |
| Female. White                                                         | v Single.                                                          |                                            | Tay 20th, 1930. 19<br>(Month) (Day) (Year)                                   |
| 5a. If married, widowed, or divorced<br>HUSBAND of                    |                                                                    |                                            | FIFY, That I attended deceased from                                          |
| (or) WIFE of                                                          |                                                                    |                                            |                                                                              |
| 6. DATE OF BIRTH (month, day and year                                 | May 20th, 1930.                                                    | l .                                        | alive on, 19                                                                 |
| 7. AGE Years Months                                                   | Days If LESS than 1 day,                                           | i                                          | d, on the date stated above, at                                              |
| -0-                                                                   | -O- hrs. or min.                                                   | The CAUSE OF DEA                           | TH* was as follows:                                                          |
| 8. OCCUPATION OF DECEASED                                             |                                                                    |                                            | <i>H</i>                                                                     |
| (a) Trade, profession, or hone particular kind of work                | _                                                                  | I'm Co                                     | bhiggea                                                                      |
| •                                                                     |                                                                    |                                            | /                                                                            |
| (b) General nature of industry,<br>business, or establishment in      |                                                                    |                                            | (duration) yrs. mos.                                                         |
| which employed (or employer)                                          |                                                                    | CONTRIBUTORY L                             | mottes Cord,                                                                 |
| (c) Name of employer                                                  |                                                                    | (Secondary)                                | (duration)yrs,mos,                                                           |
| 9. BIRTHPLACE (city or town)                                          | Lewiston, Idaho.                                                   | 18. Where was diseas                       | e contracted                                                                 |
| (State or country)                                                    | Idano.                                                             | if not at place of                         | death?                                                                       |
| 10. NAME OF FATHER  Whitman                                           | B. Cox.                                                            |                                            | ede death?                                                                   |
| 11 DIDMIDI ACE OF PAMUED (elter                                       |                                                                    | Was there an autopsy What test confirmed d |                                                                              |
| (State or Country)  2 (State or Country)  2 12. MAIDEN NAME OF MOTHER | Idaho.                                                             | (Signed)                                   | fau Hart.                                                                    |
| M                                                                     |                                                                    | 5/21/30. 19                                |                                                                              |
| 12. MAIDEN NAME OF MOTHER ME                                          | ry Beatrice Musgrave.                                              |                                            | (AUU 189)                                                                    |
| 18. BIRTHPLACE OF MOTHER (city                                        | or town) Walla Walla,                                              | *State the DISEASE                         | CAUSING DEATH, or in deaths from VIOLE MEANS AND NATURE OF INJURY, and       |
| (State or Country)                                                    | Washington.                                                        | whether ACCIDENTA                          | L, SUICIDAL, or HOMICIDAL.                                                   |
| 14. Infi. ()                                                          | 3. Co.                                                             | 19. Place of Burial, C                     | Cremation, or Removal Date of Burial                                         |
| 1 1                                                                   | /                                                                  | Lewiston, Id                               | aho. 5/22/30.                                                                |
| - / / 24                                                              | Tim You                                                            | 20. Undertaker                             | Address                                                                      |
| 15. Filed 6- / , 19 70                                                | J-111- Parliture                                                   | Brower-Wann                                | Company. Lewiston, Id ah                                                     |
|                                                                       | Registrar                                                          |                                            | TOWARD COTT & LOT BY                                                         |

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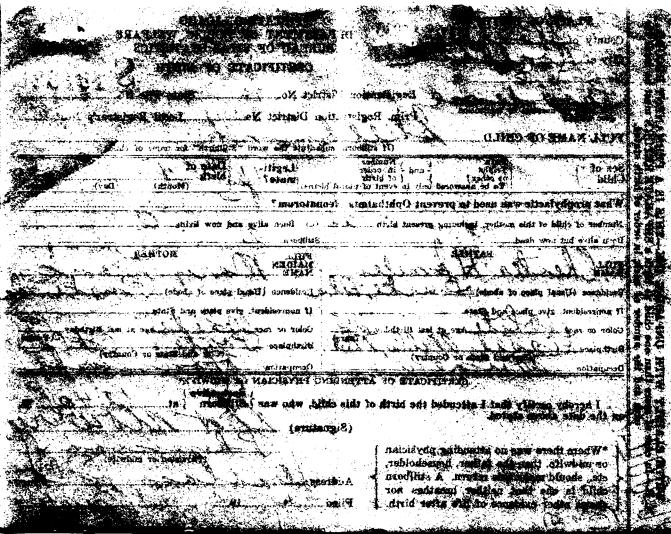
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Do not accept a certificate of death signed only by a midwife.

TATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County BUREAU OF VITAL STATISTICS State File No. Registration District No..... (If boyn in hospital or institution give name.) Prim. Registration District No. 1009 Local Registrar's No. FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of child) Number Date of Legiti-Sex of birth mate? ALA Child nucl (To be answered only in event of plural births) (Month) (Day) (Year What prophylactic was used to prevent Ophthalmia Neonatorum?  $\mu$ Number of child of this mother, including present birth Born alive and now living Born alive but now dead ..... Stillborn MOTHER FATHER FULL birth each. MAIDEN Residence (Usual place of abode) Residence (Usual place of abode). If nonresident, give place and State If nonresident, give place and State . Age at last Birthday Age at last Birthday Birthplace Birthplace (City and State or Country) City and State or Country) Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) .... \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor Address Filed Jun / 1930 Susan E shows other evidence of life after birth.

STATE OF IDAHO RECORD be made for DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No. 70 State File No. in hospital or institution Prim. Registration District No. 1011 Local Registrar's No. 55 give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Number Date of Sex of . Legiti-/ Triplet in order birth Child or other? of birth mate? (Month) (To be answered only in event of plural births) What prophylactic was used to prevent Ophthalmia Neonatorum?. Number of child of this mother, including present birth.... (a) Born slive and now living... Born alive but now dead..... Stillborn. FULL MAIDEN NAME Residence (Usual place of abode) Residence (Usual place of abode) If nonresident, give place and State Color or r Birthplace (City and State or Country) nd State or Country Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE I hereby certify that I attended the birth of this child, who was stimborn on the date above stated. (Signature) .... \*Where there was no attending physician hysician or midwife) or midwife, then the father, householder, WRITE etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



| ENT RECORD tated EXACTLY, PHYSICIAMS                                                                                                                                                                                           | PLACE OF DEATH  PLACE OF DEATH  County of Coun | DO NOT WRITE IN THIS SPACE  State File No                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MARGIN RESERVED FOR BINDING NLY, WITH UNFADING INK—THIS IS A PERMANENT ation should be carefully supplied. AGE should be state TH in plain terms, so that it may be properly classified. E instruction on back of certificate. | PERSONAL AND STATISTICAL PARTICULARS  8. SEX  4. COLOGO OR RACE  5. Single, Married, Widowed, or Divorced (write the word)  5a. If married, widowed, or divorced HUSBAND of (or) WIFE of  6. DATE OF BIRTH (month, day and year)  7. AGE  Years  Months  Days  If LESS than 1 day, hrs. or min.  8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer  9. BIRTHPLACE (city or town)  (State or country)  10. NAME OF FATHER  Mulder  A. Cologo OR RACE  5. Single, Married, Widowed, Or Divorced (write the word)  11. LESS than 1 day, hrs. or min.  12. AGE  13. AGE  14. COLOGO OR RACE  5. Single, Married, Widowed, Or Divorced (write the word)  14. LESS than 1 day, hrs. or min.  16. DATE OF BIRTHPLACE (city or town)  17. AGE  18. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of Employer  10. NAME OF FATHER  A. ARLE OF SATHER  A. COLOGO OF DECEASED  5. Single, Married, Widowed, Or Divorced (write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | MEDITATE OF DEATH  16. DATE OF DEATH  17. I HEREBY CHRTIFY, That I attended deceased from  19. to 19. to 19.  that I last saw he alive on 19.  and that dath ordered, on the date stated above, at 19.  The CAISE OF DEATH, was at follows:  (duration) yrs. mos. ds.  CONTRIBUTED (Geondary)  (duration) yrs. mos. ds.  18. Where was disease contracted if not at place of death?  Did an operation precede death of Date of Was there an adropsy |
| WRITE PLAINLY N. B.—Every item of information should state CAUSE OF DEATH i                                                                                                                                                    | 11. BIRTHPLACE OF FATHER (city or town) SSEE MillS (State or Country) Missouri  12. MAIDEN NAME OF MOTHER Mary Bauks  13. BIRTHPLACE OF MOTHER (city or town) Parter (State or Country) Whatoman  14. Informant Alster H. Duiley (Address) Murfl Jaloho.  15. Filed 4-14, 1930 Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What test confirmed discussions (Signed A. 1930 (Address) A. M. M. M. 1930 (Address) A. M.                                                                                                                                                                                                                                                                                                                      |

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STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer. Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine. etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"): Typhoid fever (never report "Typhoid Pneumonia"): Lobar pneumonia: Bronchopneumonia ("Pneumonia." unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

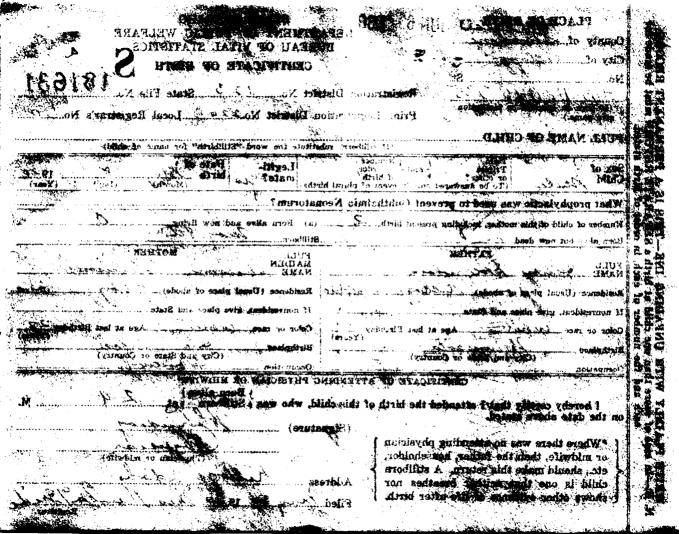
Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

| <u>k</u>                            | PLACE DE SETTED JUN 6 1930                                                                                                  | STATE OF IDAHO                                        |
|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| e for                               | County of The County of DEPA                                                                                                | RTMENT OF PUBLIC WELFARE                              |
| ğ                                   | City of Killogy                                                                                                             | JREAU OF VITAL STATISTICS                             |
| be mad                              |                                                                                                                             | CERTIFICATE OF BIRTH                                  |
|                                     | No St.                                                                                                                      | 181631                                                |
| must                                |                                                                                                                             | rict No                                               |
| E .                                 | (If born in hospital or institution give name.) Prim. Registratio                                                           | n District No. 2.25 f. Local Registrar's No. 60       |
| TUK!<br>tated.                      | FULL NAME OF CHILD Stillbirn, sub                                                                                           | stitute the word "Stillbirth" for name of child)      |
| TE RETURN<br>birth stated.          | Sex of Child Male. Twin triplet and Number in order or other? A and Sex of birth (To be answered only in event of plural bi | Legiti- mate? y Date of May 1920 (Month) (Day) (Year) |
| S to                                | What prophylactic was used to prevent Ophthalmia Neo                                                                        | natorum?                                              |
| EPA<br>rder                         | Number of child of this mother, including present birth                                                                     | (a) Born alive and now living                         |
| 20 O                                | Born alive but now dead                                                                                                     | Stillborn                                             |
| birth a<br>each, in                 | FATHER FULL NAME Yenry Doerndorf                                                                                            | FULL MOTHER MAIDEN Vilomina Bleisnes                  |
| at b<br>of ea                       | Residence (Usual place of abode) Tulogg Sulatio                                                                             | Residence (Usual place of abode) Clago Sheho          |
|                                     | If nonresident, give place and State                                                                                        | If nonresident, give place and State                  |
| re than one child<br>and the number | Color or race White Age at last Birthday (Years)                                                                            | Color or race White Age at last Birthday 27           |
| n n                                 | Birthplace Minnesola                                                                                                        | Birthplace Adaho (Italia)                             |
| ihe.                                | (City and State or Country) Occupation                                                                                      | Occupation (City and State or Country)                |
| d t                                 | CERTIFICATE OF ATTENDIN                                                                                                     |                                                       |
| more<br>ch an                       | I hereby certify that I attended the birth of this chi                                                                      | (Born alive)                                          |
| 9 8                                 | on the date above stated. (Sign                                                                                             | ature) Wayidaay                                       |
| Case                                | ( *Where there was no attending physician )                                                                                 | (Shaper an                                            |
|                                     | or midwife, then the father, householder,                                                                                   | (Physician or midwife)                                |
| <b>5</b>                            | detc., should make this return. A stillborn                                                                                 | Killon Idahi.                                         |
| 4                                   | child is one that neither breathes nor Addresshows other evidence of life after birth.                                      | 9 7 90                                                |
| ż                                   | Filed.                                                                                                                      |                                                       |
| ۱ ۲                                 |                                                                                                                             | Registrar.                                            |



| 2                                                              | RECEIVEL JUN 6 1030 STATE OF IDA                                                                | но                                                                                                                                                            |
|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| AN A                                                           | DEPARTMENT OF PUBLI                                                                             | C WELFARE DO NOT WRITE IN THIS SPACE                                                                                                                          |
| _ <u>25</u> 5 →                                                | PLACE OF DEATH BUREAU OF VITAL ST                                                               | ATISTICS                                                                                                                                                      |
| YS                                                             | County of Shore CERTIFICATE OF                                                                  | DEATH State File No                                                                                                                                           |
| PH                                                             | Registration District No                                                                        | /2 3                                                                                                                                                          |
| Y,<br>ent                                                      | City of Primary Registration District                                                           | No. 2 201 Local Registrar's No. 2                                                                                                                             |
| O L E                                                          | (No                                                                                             | )                                                                                                                                                             |
| OR<br>AC<br>star                                               | (If death occurred in a hospital or institution, give its                                       | name instead of street and number.)                                                                                                                           |
| ENT RECORD stated EXACTLY, PHYSICIA d. Exact statement of OCCU | 2. FULL NAME DOUG COESAND                                                                       | TY.                                                                                                                                                           |
| EX B                                                           | (a) Residence. No                                                                               | St.                                                                                                                                                           |
|                                                                | (Usual place of abode)  Length of residence in city or town where death occurred. yrs. mos. ds. | (If nonresident give city or town and State)  How long in U. S., if of foreign birth? yrs. mos. ds.                                                           |
| PERMANENT<br>lould be state<br>r classified. E                 | PERSONAL AND STATISTICAL PARTICULARS                                                            | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |
| M.A.                                                           | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed,                                            | 16. DATE OF DEATH                                                                                                                                             |
| ING<br>N PERN<br>should<br>rly class                           | M, what or Divorced (write the word)                                                            | may 18 1930                                                                                                                                                   |
| BINDIN<br>IS A P<br>AGE sho<br>properly                        | 5a. If married, widowed, or divorced                                                            | (Month) (Day) (Year)                                                                                                                                          |
| BINI<br>AGE<br>Prope                                           | HUSBAND of (or) WIFE of                                                                         | 13. I HEREBY CERTIFY, That I attended deceased from                                                                                                           |
| S I S                                                          | A DAME OF PURMY (work June 1                                                                    | , 19, 19                                                                                                                                                      |
| P & P P P P P P P P P P P P P P P P P P                        | 6. DATE OF BIRTH (month, day and year)  7. AGE Years Months Days If LESS than 1 day,            | that I last saw h alive on 19                                                                                                                                 |
| CVED FOUNK—TI<br>Supplied<br>it may<br>tificate.               | hrs. or                                                                                         | and that death occurred, on the date stated above, at                                                                                                         |
| CVED<br>INK—<br>supplic<br>it ma<br>tificate                   | 8. OCCUPATION OF DECEASED                                                                       | Stell born albumores on                                                                                                                                       |
|                                                                |                                                                                                 | part 2 mother.                                                                                                                                                |
| FSE<br>ING<br>Tha                                              | (a) Trade, profession, or particular kind of work                                               |                                                                                                                                                               |
| N KES<br>FADIN(<br>carefull<br>s, so th                        | (b) General nature of industry,<br>business, or establishment in                                | (duration)yrsmosds,                                                                                                                                           |
| 多牙 、自奉                                                         | which employed (or employer)                                                                    | CONTRIBUTORY                                                                                                                                                  |
| UN De terr                                                     | (c) Name of employer                                                                            | (Secondary)                                                                                                                                                   |
| 1 <b>= 7</b> . 1                                               | 9. BIRTHPLACE (city or town)                                                                    | (duration)yrsmosds.                                                                                                                                           |
| WITE<br>Shoule<br>plain<br>ction                               | (State or country)                                                                              | if not at place of death?                                                                                                                                     |
| on on stru                                                     | 10. NAME OF FATHER                                                                              | Did an operation precede death?                                                                                                                               |
| PLAINLY,<br>information<br>DEATH in<br>See instri              | 11. BIRTHPLACE OF FATHER (city or town)                                                         | Was there an autopsy? 200.                                                                                                                                    |
| Sea LA                                                         | (State or Country)                                                                              | What test confirmed diagnosis? Masteration foody                                                                                                              |
| Fig.                                                           | (State or Country)  12. MAIDEN NAME DE MOTHER  12. MAIDEN NAME DE MOTHER                        | (Signed) , M. D.                                                                                                                                              |
| of in OF                                                       | 12. MAIDEN NAMEDE MOTHER BUILDING                                                               | , 19.30 · (Address)                                                                                                                                           |
| WRITE<br>item of<br>AUSE OF<br>important                       | 18. BIRTHPLACE OF MOTHER (city or town)                                                         | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| ii Ait                                                         | (State or Country)                                                                              | whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                   |
| ste C                                                          | Informant of the state of the state of                                                          | 19. Place of Burial, Cremation, or Removal Date of Burial                                                                                                     |
| Every<br>state (<br>is very                                    | (Address)                                                                                       | Tellinga Id. may 20130                                                                                                                                        |
|                                                                | 15. 7                                                                                           | 20. Undertaker Address                                                                                                                                        |
| N. B.<br>should<br>TION                                        | Filed May 30, 1930 Mis The Registrar                                                            | M. P. Thornhild Tellow Ide                                                                                                                                    |
| 겨울다                                                            |                                                                                                 |                                                                                                                                                               |

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"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS Maileall death certicates filed with your to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

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midwife.

|                             | ,                                                                                                                                                                           | 1 ( * ( * ( * )                                   |               |
|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---------------|
| L.                          | PLACEFOR BERTHE JIN 9 1930                                                                                                                                                  | STATE OF IDAHO                                    |               |
| المو                        | County ofDEPA                                                                                                                                                               | RIMENT OF PUBLIC WELFARE                          | 7             |
| RECORI<br>be made           | Ri Ri                                                                                                                                                                       | UREAU OF VETAL SPATISTICS                         |               |
| <u>ا ۾ چ</u>                | City of Addition Addition .                                                                                                                                                 |                                                   |               |
| E E                         | No. 1 6 224 07-23 2 St. 7                                                                                                                                                   | CERTIFICATE OF BUILD                              | (X).          |
|                             |                                                                                                                                                                             | rict No. 37 State File                            | 557           |
| ENT<br>must                 | - Section                                                                                                                                                                   | Aict No                                           |               |
|                             | (If born in hospital or institution give name.)  Prim. Registration                                                                                                         | n District No. 2.0.8 Local Registrar's No.        |               |
| \$₩\$                       | FULL NAME OF CHILD                                                                                                                                                          | lma. Maner                                        |               |
| ERMAN<br>ETURN 1<br>stated. | (If stillborn, su)                                                                                                                                                          | ostitute the word "Stillbirth" for name of child) |               |
| E E E                       | Twin   Number                                                                                                                                                               |                                                   |               |
| 4 M T                       | Sex of Female Triplet or other?                                                                                                                                             | Legiti- Date of 5 - 24 -                          | 19 <i>3</i> ط |
| SE P                        | (To be answered only in event of plural bi                                                                                                                                  |                                                   | (Year)        |
| & B.                        | What prophylactic was used to prevent Ophthalmia Neo                                                                                                                        | natorum? Nane.                                    |               |
| F P                         | Number of child of this mother, including present birth                                                                                                                     | (a) Born alive and now living / O                 |               |
| SEL                         | l                                                                                                                                                                           | /                                                 |               |
| #.E                         | Born alive but now dead Q                                                                                                                                                   | Stillborn                                         |               |
| Z 4 4                       | FULL A T                                                                                                                                                                    | FULL MOTHER MAIDEN                                | 1             |
| bir I                       | NAME Tilliam Receive May a                                                                                                                                                  | NAME // UNILL Packe Ka                            | rga           |
| at D                        | Residence (Usual place of abode) Mustaugh,                                                                                                                                  | Residence (Usual place of abode) Mustaugh         | Ida           |
| I d I                       | If nonresident, give place, and State                                                                                                                                       | If nonresident, give place and State              |               |
| FAD<br>child<br>nber        | 42                                                                                                                                                                          | 41, 1, 4                                          | 34            |
| 2 5 5                       | Color or race. Age at last Birthday (Years)                                                                                                                                 | Color or race Age at last Birthday                | (Years)       |
| 밀통되                         | Birthplace Muslimill, Mak                                                                                                                                                   | Birthplace (City and State or Country)            | 2             |
| 田田田                         | Occupation Taxwer                                                                                                                                                           | Occupation Naulluil                               |               |
| 불년교                         | CERTIFICATE OF ATTENDIN                                                                                                                                                     |                                                   |               |
| _ 5 E                       |                                                                                                                                                                             | Bear allive 7 13                                  | 2             |
| See                         | I hereby certify that I attended the birth of this chi                                                                                                                      | ld, who was hStillborn hat                        | M.            |
| 2 % S                       | on the date above stated.                                                                                                                                                   | ature) It laws                                    |               |
|                             | (Bigid)                                                                                                                                                                     | ature)                                            | ·····         |
| PL/                         | *Where there was no attending physician                                                                                                                                     | <i>y</i> .                                        |               |
| 25                          | or midwife, then the father, householder,                                                                                                                                   | (Physician or midwife)                            | ,             |
| 57 /                        | $\left  \left\langle \right\rangle \right $ etc., should make this return. A stillborn $\left\langle \right\rangle = \left\langle \left\langle \right\rangle \right\rangle$ | ss / milesty Ida                                  | ho            |
| <u>₹</u> ¤i                 | child is one that neither breathes nor                                                                                                                                      | is 10.14 = 0                                      |               |
| ż                           | shows other evidence of life after birth.   Filed.                                                                                                                          | 6 - 4 - 1930 Clashelf & Smil                      | igtvar        |
|                             |                                                                                                                                                                             | O PORT                                            | THAT !        |



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STATE OF IDAHO stated EXACTLY, PHYSICIANS DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS E OF DRATH CERTIFICATE OF DEATH State File No. County of Registration District No..... Local Registrar's No. Primary Registration District No. 2085 IS A PERMANENT RECORD FULL NAME Residence. No.... (If nonresident give city or town and State) (Usual place of abode) How long in U. S., if of foreign birth? Length of residence in city or town where death occurred. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS ngle, Married, Widowed. 16. DATE OF DEATH 8. SEX plnous vorced (waite the word) (Month) 5a. If married, widowed, or divorced HUSBAND of 17. I HEREBY CERTIFY, That I extended deceased from (or) WIFE of that I last saw h\_\_\_\_\_ alive on\_\_\_\_\_\_ 10\_\_\_\_\_\_\_ 6. DATE OF BIRTH (month, day and year) If LESS than 1 day. Months Davs 7. AGE and that death occurred, on the date stated above, at \_\_\_\_\_\_\_m, The CAUSE OF DEATH\* was as follows: OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in (duration) \_\_\_\_\_yrs. \_\_\_\_mos. \_\_\_\_ds which employed (or employer) CONTRIBUTORY (c) Name of employer (Secondary) (duration) \_\_\_\_\_vrs. \_\_\_mos. \_\_\_ BIRTHPLACE (city or town) 18. Where was disease contracted (State or country) if not at place of death? 10. NAME OF FATHER Did an operation precede death? Date of ...... Was there an autopsy? What test confirmed diagnosis? PARENTS 11. BIRTHPLACE OF FATHER (city or town (State or Country) 12. MAIDEN NAME OF MOTHER item o AUSE \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE OF MOTHER (city or town) .... (State or Country) Place of Burial, Cremation, or Removal Date of Burial Informan (Address) Undertaker Filed..... Registrar

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of ager For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of filness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the ISEASE CAUSING DEATH (the primary affection with spect to time and causation), using always the same cepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of ...... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough: Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis." etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide: Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

UTY OF LOCAL REGISTRARS—Mail all death certise filed with you to the State Registrar on or before the fith of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year very number one. Carefully examine each certificate before assuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

0 6 1

STATE OF IDAHO must be made County of Washing Lin DEPARTMENT OF PUBLIC WELFARE NENT RECORD BUREAU OF VITAL STATISTICS City of Weesen CERTIFICATE OF BIRTH Registration District No. 86 State File No. 181696 mouhad (If born in hospital or institution Prim. Registration District No. 1010 Local Registrar's No. 27 give name.) (If stillborn, substitute the word "Stillbirth" for name of child) FULL NAME OF CHILD..... Number and in order Date of mate? 446 birth 3 -Sex of Triplet Child Male or other? (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? birth FULL MOTHER FATHER NAME Stomer Wiggins NAME Place Mandey child Residence (Usual place of abode) Residence (Usual place of abode) If non-resident, give place and State ... YYA CANTALE It non-resident, give place and State Midwale Ida one Color or race White Age at last Birthday 20 Color or race LA Litt. Age at last Birthday 23 (Years) Birthplace Salem mo (Ivais) (City and State or County) (City and State or County) Occupation James Occupation James Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE Bern allive on the date above stated. **C8.80** (Signature) 4 Mest Q, Finner WRITE B.—In \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor Address Filed 5/5/30 19 shows other evidence of life after birth. Registrar.

C WELFARE Registration District No. Prim. Registration District No. 1. Local Registrar's Mr. ill stillbers squattrate the word "Stillbirth" for name of called Lod must and in arder Late of (Asgolf) (To be asswered only in oven of plural bieflas) the property was used to prevent Ophthologia Nunatorgani? without of the corner including present birth. .............. (64) Burn allye and now nying. MILITARY TO THE PROPERTY OF THE PARTY OF THE Burn ulive but now days. PATHER Rentince (Usual short alcula Trenday (February 18 and 18 Pictinday (February 17 College) ("nior on right, with the state of the S. S. Dirthplaor AND PLACE OF COUNTY) (City stop State of Canada Dollagung . Authorities and Authorities an CHATTETCATE OF ATTENDED PIETRICAN OF STAM I have carried that I attended the birth of this child, attended buildings The the Contract (Stenature) Refere there was no attending physician ; or medorife, then the father, homselfolder, the statute and collection. A subborn THE RESIDENCE OF THE PERSON NAMED IN

| F RECORD  ed EXACTLY, PHYSICIANS  Exact statement of OCCUPA-                                         | PLACE OF DEATH County of Washington City of Place Of Death Registration District No Primary Registration District (No Primary Registration District (No  At death occurred in a hyspital or institution, give its registration) | DO NOT WRITE IN THIS SPACE ATISTICS DEATH  State File No                                                                                                      |
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| MANENT R<br>be stated<br>ssified. Exa                                                                | 2. FULL NAME  (a) Residence. No (Usual place of abode)  Length of residence in city or town where death occurred. yrs. mos. ds.  PERSONAL AND STATISTICAL PARTICULARS  3. SEX  4. COLOR OR RACE  5. Single, Married, Widowed, or Divorge (write the word)                                                                                          | St.  (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.  MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH      |
| OR BINDI<br>HIS IS A<br>AGE al                                                                       | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of  6. DATE OF BIRTH (month, day and year)  7. AGE Years Months Days If LESS than 1 day, hrs. or                                                                                                                                                                                         | 193                                                                                                                                                           |
| IRGIN RESERVED FOUNFADING INK—TI be carefully supplied terms, so that it may an back of certificate. | 8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer                                                                                                                                                     | The CAUSE OF DEATH* was as follows:  Tremature Atall  Birth (duration) 12 100.  CONTRIBUTORY TO KILLERY (Segments)                                            |
| MA  (, WITH  n should  in plain t                                                                    | 9. BIRTHPLACE (city or town)  10. NAME OF FATHER  11. DEPONIES OF FATHER                                                                                                                                                                                                                                                                           | (duration) yrs. ,mos. ds.  18. Where was disease entracted if not at place of death?  Did an operation precede death?  Date of was there an autopsy?          |
| WRITE PLAINLY WRITE OF Information (AUSE OF DEATH important. See inst                                | (State or Country)  12. MAIDEN NAME OF MOTHER (city or town)  18. BIRTHPLACE OF MOTHER (city or town)  (State or Country)                                                                                                                                                                                                                          | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| 8   6 %   N. B.—Every   should state CATION is very i                                                | 14. Informant Jones Wiggeics (Address) Midvale Sig  15. Filed Med 14 <sup>th</sup> , 1926. Milling M. Registrar                                                                                                                                                                                                                                    | 19. Place of Burial, Cremation, or Removal  Medvale Ide III 193  20. Hindertaken Address  V. C. Northam Ween I                                                |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager." "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"): Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia." unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of ...... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Stank," "Willess," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

396/1/0,601/466 PLACE DOCK VED JUL 9 STATE OF IDAHO DEPARTMENT OF PUBLIC WALFARE County of..... BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No......State File No. (If born in hospital or institution Prim. Registration District No. 2004 Local Registrar's No. 286 give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Date of birth Sex of Child Legiti-Triplet in order mate? (To be answered only in event of plural births) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead .......Stillborn ..... FULL MAIDEN Residence (Usual place of abode) 3/5 WOTA If non-resident, give place and State It non-resident, give place and State (City and State or County) Occupation Sandwife CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Filed 6 10 1930 (1)

Registration Ligited No. Prim. Registration Matrice No. THE NAME OF CHILD the stillness gangeltate the word 'Stillmein' transfire M? Nun her Logitt. | May 94 Lights to Commenced with received of the state of the Twenty Services

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Direction (filts and State on 1966) netranous de la companya della companya de la companya de la companya della compa CERTIFICATE OF ATTENDING PHYMETIN OF MINERAL

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|---------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------|
| li                                                      | RECEIVED JUL 9 1980                                                                        | STATE OF IDA                                               | НО                                                                                                                                                                                              | Liv Coa                                                   |                        |
|                                                         | KECELACE JOE 3 1860                                                                        | DEPARTMENT OF PUBLIC WELFARE                               |                                                                                                                                                                                                 | DO NOT WRITE IN TH                                        |                        |
| AN -                                                    | PLACE OF DEATH                                                                             | BUREAU OF VITAL S                                          | TATISTICS                                                                                                                                                                                       | State File No                                             | 70771                  |
| ICI                                                     | ٠.٠٠.                                                                                      | CERTIFICATE OF DEATH                                       |                                                                                                                                                                                                 | Double 1 He 110.                                          |                        |
| PHYSICIAN                                               | County of ACE City of Boise                                                                | Registration District No                                   | 2                                                                                                                                                                                               |                                                           | 155                    |
| E.                                                      | City ofDOZDO                                                                               | Primary Registration District                              | No. 100                                                                                                                                                                                         | Local Regi                                                | strar's No. 173        |
|                                                         |                                                                                            | (No. St Lukes H                                            | ospital.                                                                                                                                                                                        |                                                           | 16                     |
| F 55 E                                                  |                                                                                            | rred in a hospital or institution, give                    |                                                                                                                                                                                                 |                                                           | 0                      |
| AC                                                      | 2. FULL NAME Melvin Ken                                                                    | neth Troxel.                                               | ·····                                                                                                                                                                                           | •                                                         | • /                    |
| Clas C                                                  | (a) Residence No. 2315.                                                                    | Woodlawn Street.                                           | St.                                                                                                                                                                                             | (If nonresident give city                                 | on town and State)     |
| ted<br>erly<br>tions                                    | (Usual place of abode.) Length of residence in city or town where                          | death occured. yrs. mos.                                   | ds. How long                                                                                                                                                                                    | in U. S. if of foreign birth?                             | yrs. mod. ds.          |
| sta<br>prope                                            | PERSONAL AND STATISTICA                                                                    | AL PARTICULARS                                             |                                                                                                                                                                                                 | MEDICAL CERTIFICATE OF I                                  | DEATH                  |
| RECORD nould be may be I See ins                        | 8. SEX 4. COLOR OR RACE Male. White.                                                       | 5. Single, Married, Widowed, or Divorced (write the word.) | 16. DATE OF                                                                                                                                                                                     | June >                                                    | 10 , 1930              |
| BINDING<br>IENT REGGE shoul<br>at it may<br>rtant. So   | 5a. If married, widowed, or divorced HUSBAND of                                            |                                                            | 17. I HEREBY                                                                                                                                                                                    | (Month) (Day                                              | eased from             |
|                                                         | (or) WIFE of  6. DATE OF BIRTH (month, day and year)                                       | 7. 30.3070                                                 |                                                                                                                                                                                                 |                                                           | , 19                   |
| FOR RMA                                                 | T                                                                                          | June 10.1930 ays If LESS than 1 day,                       | that I last saw                                                                                                                                                                                 | th occurred, on the date stated                           | above at <b>7 %</b> m. |
| _ E &                                                   |                                                                                            | 0hrs, or                                                   | *State the DI                                                                                                                                                                                   | SEASE CAUSING DEATH, or it                                | n deaths from VIOLENT  |
| RESERVED IIS IS A P fully suppli plain term FION is ver | 8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work None.         |                                                            | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The DUSE OF DEATH* was as follows: |                                                           |                        |
| ## P # 5                                                | (b) General nature of industry, business, or establishment in which employed (or employer) |                                                            |                                                                                                                                                                                                 |                                                           |                        |
| ARGIN NK—T be car ATH in                                | (c) Name of employer                                                                       |                                                            |                                                                                                                                                                                                 |                                                           |                        |
| MG 1<br>NG 1<br>nould<br>F DE<br>of O                   | 9. BIRTHPLACE (city or town) Bois<br>(State or country)                                    | e, Idaho.                                                  | CONTRIBUTO                                                                                                                                                                                      | oursied.                                                  | Retus da.              |
| I UNFADING<br>ormation shou<br>CAUSE OF I               | 10. NAME OF FATHER                                                                         | A. Troxel.                                                 | (Secondary)                                                                                                                                                                                     |                                                           | mosds.                 |
|                                                         |                                                                                            |                                                            | if not at                                                                                                                                                                                       | s disease contracted place of death? on precede death? Da |                        |
| WITH<br>of info<br>d state<br>Exact                     | 11. BIRTHPLACE OF FATHER (city of State or Country)  12. MAIDEN NAME OF MOTHER A           | lpha. B. Mooney.                                           | Was there an                                                                                                                                                                                    | autopsy?                                                  | 0 —                    |
| INLY,<br>item<br>shoul                                  | 13. BIRTHPLACE OF MOTHER (city of (State or County)                                        |                                                            | (Signed)                                                                                                                                                                                        | 19 30 (Address)                                           | ball M.D.              |
| FVE FLAINLE                                             | 14. Informant Ward. A. Trox                                                                | el.                                                        |                                                                                                                                                                                                 | Burial, Cremation, or Removal                             | Date of Burial         |
| WRITE PLA<br>N. B.—Every                                | (Address) 2315. Woodlawn                                                                   | St, Boise, Ideho.                                          | Morris 20. Undertake                                                                                                                                                                            | H111 Cemetery.                                            | June. 10.50.           |
| ۶z                                                      | 16. Filed 6-70, 19.30                                                                      | Registrar.                                                 | Summers                                                                                                                                                                                         | & Krebs.                                                  | Boise, Ida             |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect. Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery: (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

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Do not accept a certificate of death signed only by a midwife.

| RD<br>le for                       | I COUNTY OF A STATE OF THE STAT | STATE OF IDAHO ARTMENT OF PUBLIC WELFARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| T RECORD<br>st be made for         | City of Hot BC No St St Registration Dist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CERTIFICATE OF BIRTH S 181826  rict No. State File |
| ERMANENT<br>ETURN must<br>stated.  | (If born in hospital or institution give name.)  FULL NAME OF CHILD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | p District No2/6/ Local Registrar's No. 788                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| S A PER<br>VTE RET<br>birth sta    | Sex of Twin Child Triplet or other?  (If stillborn, subsets of life stillbo | rths) Legitimate?  Date of birth (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| THIS I                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (a) Born alive and now living Stillborn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| NG INK<br>at birth a<br>of each, i | FULL John Hell Blotham Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | FULL MAIDEN MOTHER MAIDEN SINGA PLANA HOLDING Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| UNFADI<br>ne child<br>number       | If nonresident, give place and State  Color or race What Age at last Birthday (Years)  Birthplace Owney (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | If nonresident, give place and State  Color or race A August Age at last Birthday 29  Birthplace 9 Management City (Mairs)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| VITH<br>than of                    | Occupation (City and State of Country)  CERTIFICATE OF ATTENDIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Occupation State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| AINLY Ve of more each an           | I hereby certify that I attended the birth of this chi<br>on the date above stated.  (Signal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ld, who was Stillborn at M.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| /RITE PL<br>3.—In case             | *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| z.                                 | shows other evidence of life after birth. Filed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | une 30 1988 Min G. G. Fetterar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

DEPARTMENT OF BUREAU. OF VITAL CERTIFICATE OF Registration Distinct No. tha P Cation District No. 1 Local Registrar's No. 2 thinks to sman and distributes?" brew and mouthedge modellite li. Taism and and the second standard of of this contains, including present birth ... (a) Born slive and now Butter Residence (Usual place of abode) Laries Remigoco (Esual place of abode) ..... If monegation, wire place and state ... If nonresident, give place and State... Color or rane of the Markette at last Methoday. Birthplace (City and State or Corpty) Occupation and All Land GENERAL OF APPLIABLE PRISIDLY OF MINISTER Artie moli i I hereby certify that I attended the birth of this child, who was I Stillborn (Surature) ..... "Where there was no attending physician (Physicien or michile) or midwife, then the father, honselfolder, etc., should make this return. A stillborn child is one that neither breathes nor shoves other evidence of life after birth.

| RECEIVED JUL 2 163                                               | STATE OF IDA                                              | HO C WELFARE DO NOT WRITE                                                | E IN THIS SPACE                  |
|------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------|
| PLACE OF DEATH                                                   | BUREAU OF VITAL ST                                        | ATISTICS DO NOT WRITE                                                    | ty () O O O                      |
| Kanach                                                           | CERTIFICATE OF                                            | DEATH State File No                                                      | 70822                            |
| County of Sun Wall                                               | Registration District No                                  | 87 - Land Barin                                                          | 186                              |
| City of A. A.V. A. H. S.     | rimary Registration District                              | No. 2/6/ Local Regist                                                    | rar's No                         |
|                                                                  | (No                                                       | )                                                                        | i.                               |
| (If death coursed                                                | ed in phespital of institution, give its                  | name instead of street and number.)                                      | O <sup>V</sup>                   |
| 2. FULL NAME                                                     | way                                                       |                                                                          |                                  |
| (a) Residence. No                                                | Hor springs                                               | St. (If nonresident give ci                                              |                                  |
| Length of residence in city or town where dea                    | ath occurred. yrs. mos. ds.                               | How long in U. S., if of foreign birth?                                  | yrs. mos. ds.                    |
| PERSONAL AND STATISTICA                                          |                                                           | MEDICAL CERTIFICATE OF                                                   | DEATH                            |
| 8. SEX 4. COLOR OF RACE                                          | 5. Single, Married, Widowed, or Diverged (write the word) | 16. DATE OF DEATH                                                        | 15- 36                           |
| Male While                                                       | Single                                                    | (Month)                                                                  | (Day) (Year)                     |
| 5a. If married, widowed, or divorced<br>HUSBAND of               |                                                           | 17. HEREBY CERTIFY, That I attended                                      | deceased from Abu                |
| (or) WIFE of                                                     |                                                           | Jelene 15, 1830, to                                                      | 7 . 19                           |
| 6. DATE OF BIRTH (month, day and year)                           | Te T DOG About 1 dogs                                     | (that I last saw h alive on                                              | leved 19                         |
| 7. AGE Years Months                                              | Days If LESS than 1 day, hrs. or                          | and that death occurred, on the date stated al                           | ove, at                          |
|                                                                  | min.                                                      | The CAUSE OF DEATH* was as follows:                                      | (Died in                         |
| 8. OCCUPATION OF DECEASED                                        | 20 8 -                                                    | entero at lemo a                                                         | estation                         |
| (a) Trade, profession, or particular kind of work                |                                                           |                                                                          |                                  |
| (b) General nature of industry,<br>business, or establishment in |                                                           | (duration)                                                               | yrs d                            |
| which employed (or employer)                                     |                                                           | CONTRIBUTORY (MANA (Secondary)                                           | wi                               |
| (c) Name of employer                                             |                                                           |                                                                          | yrsmosds                         |
| 9. BIRTHPLACE (city or town)                                     | va Hot Offeringo                                          | 18. Where was disease contracted                                         |                                  |
| (State or country)  10. NAME OF FATHER                           | De Propi                                                  | if not at place of death?  Did an operation precede death?  DD D         | ata of                           |
| 10. NAME OF FATHER TOWN                                          | Weste Blochan                                             | Was there an autopsy?                                                    | oc VI                            |
| 11. BIRTHPLACE OF FATHER (city or (State or Country)             | r town) of our                                            | What test confirmed diagnosis?                                           | <del>~</del>                     |
| (State of Country)                                               | Idaho.                                                    | (Signed)                                                                 | M. I                             |
| (State or Country)  11. MAIDEN NAME OF MOTHER                    | In Of Godfre                                              | 0-13., 1930. (Address)                                                   | wa Hol Gary                      |
|                                                                  | or town to Wahana att                                     | *State the DISEASE CAUSING DEATH, o<br>CAUSES, state (1) MEANS AND NATUR | r in deaths from VIOLEN          |
| (State or Country)                                               | Wah                                                       | CAUSES, state (1) MEANS AND NATURE whether ACCIDENTAL, SUICIDAL, or HO   | RE OF INJURY, and (2<br>MICIDAL. |
| 14. July Mes                                                     | 1. Blox Land                                              | 19. Place of Burial, Cremation, or Removal                               | Date of Burial                   |
| Informant                                                        | Sein D. COR.                                              |                                                                          | 19                               |
| (Address) Fava AV                                                | m. O JOL L                                                | 20. Undertaker                                                           | Address                          |
| 15. Filed (10 30 , 193)                                          | Registrar                                                 |                                                                          |                                  |
| (/                                                               |                                                           |                                                                          |                                  |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman. (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications. as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH-Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia: Bronchopneumonia ("Pneumonia," unqualified, is indefinite): Tuberculosis of lungs. meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere chopheumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS-Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

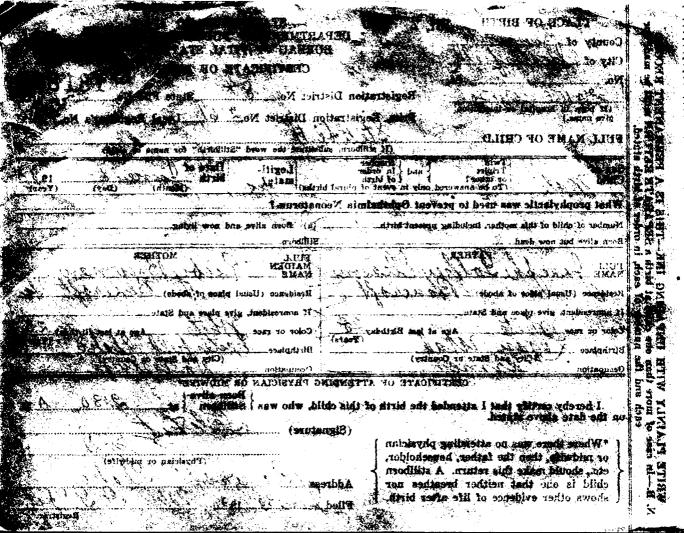
Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

1930 RECORD be made for STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH PERMANENT I RETURN must bethe stated. Registration District No. State File No..... (If born in hospital or institution Prim. Registration District No. 2/6/ Local Registrar's No. 786 give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Date of birth Sex of Legiti-Triplet in order Child or other? birth of birth (To be answered only in event of plural births) Month) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth... (a) Born alive and now living. Born alive but now dead. Stillborn. FULL MAIDEN NAME UNFADING one child at bi number of ea Residence (Usual place of/abode) If nonresident, give place and State If nonresident, give place and State Color or race. at last Birthday Color or race (Years) Birthplace .... Birthplace. (City and State or Country) (City and State or Country, Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* Born alive 2130 I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. z



| County of Banatical Registration District No. 26  City of Chesterful Primary Registration District No. 20/6/  (No. (If death occurred in a hospital or institution, give its name instead instead of street and number of the | Å.O.                       |
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| Long the distribution of the little distribution | own and State)<br>mos. ds. |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | гн                         |
| male White Single Wildwed, 16 DATE OF DEATH  Or Divorced (write the word)  Month  (Day)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 19.3 (Year)                |
| The property of the property o |                            |
| TO DATE OF BIRTH (month, day and year) that I last saw in all of the saw in that I last saw in the I last saw in | , at m.                    |
| The CAUSE OF DEATH* was as follows:    Age   Tears   Months   Days   1 day, 2 hrs. or min.   The CAUSE OF DEATH* was as follows:    Age   Tears   Months   Days   1 day, 2 hrs. or min.   The CAUSE OF DEATH* was as follows:    Age   Tears   Months   Days   The CAUSE OF DEATH* was as follows:    Age   Tears   Months   Days   The CAUSE OF DEATH* was as follows:    Age   Tears   Months   Days   The CAUSE OF DEATH* was as follows:    Age   Tears   Months   Days   The CAUSE OF DEATH* was as follows:    Age   Tears   Months   Days   The CAUSE OF DEATH* was as follows:    Age   Tears   Months   Days   The CAUSE OF DEATH* was as follows:    Age   Tears   The CAUSE OF DEATH* was as follows:    Age   Tears   The CAUSE OF DEATH* was as follows:    Age   Tears   The CAUSE OF DEATH* was as follows:    Age   Tears   The CAUSE OF DEATH* was as follows:    Age   Tears   The CAUSE OF DEATH* was as follows:    Age   Tears   The CAUSE OF DEATH* was as follows:    Age   Tears   The CAUSE OF DEATH* was as follows:    Age   Tears   The CAUSE OF DEATH* was as follows:    Age   Tears   The CAUSE OF DEATH* was as follows:    Age   Tears   The CAUSE OF DEATH* was as follows:    Age   Tears   The CAUSE OF DEATH* was as follows:    Age   Tears   The CAUSE OF DEATH* was as follows:    Age   The CAUSE OF DEATH* was as follows:   Age   The CAUSE OF DEATH* was as follows:   Age   The CAUSE OF DEATH* was as follows:   Age   The CAUSE OF DEATH* was as follows:   Age   The CAUSE OF DEATH* was as follows:   Age   The CAUSE OF DEATH* was as follows:   Age   The CAUSE OF DEATH* was as follows:   Age   The CAUSE OF DEATH* was as follows:   Age   The CAUS |                            |
| (b) General nature of industry, business, or establishment in which employed (or employer) yrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | mos ds.                    |
| NAME OF EMPLOYEE  Chests of the Same (duration) yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                            |
| S s s s s s s s s s s s s s s s s s s s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                            |
| Did an operation precede death? Led Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                            |
| What test confirmed diagnosis?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | , M. D.                    |
| A. H. G. I WAIDEN NAME OF MOTHER JAWMAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                            |
| 13 BIRTHPLACE OF MOTHER (city or town) (State or country)  LENT CAUSES, state (1) MEANS AND NATUR and (2) whether ACCIDENTAL, SUICIDAL, or HO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | RE OF INJURY,              |
| Informant//// Information, or Removal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Date of Burial<br>19       |
| Hand (Address) Bancoll Ska  (Address) Bancoll Ska  20. Undertaker  Filed word 30, 1930 Fig.  Filed word 30, 1930 Fig.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Address                    |

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DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

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Do not accept a certificate of death signed only by a mid-wife.

PROMEVED JUL 1 0 1930 STATE OF IDAHO County of Bannack DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No. State File SEPARATE REFURN in order of birth stated (If born in hospital or institution give name.) Prim. Registration District No. Local Registrar's No. 78 FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number Sex of Triplet Legiti- . o Date of in order Child or other? of birth birth ..... mate? (To be answered only in event of plural births) (Month) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth...... (a) Born alive and now living..... Born alive but now dead......Stillborn FATHER FULL FULL MOTHER MAIDEN UNFADING one child at NAME ..... Residence (Usual place of abode). 320 27 Residence (Usual place of abode) 320 71 It non-resident, give place and State If non-resident, give place and State\_\_\_\_\_ Color or race ..... than Birthplace (Years) City and State or County) City and State or County) Occupation C Occupation . more each a CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was \ Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. 

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| ŽŽ                                                   | RECEIVED JUL 10 1930 DEPARTMENT OF PUBLI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   |
|                                                      | PLACE OF DEATH BUREAU OF VITAL ST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   |
| PHYSICIANS<br>t of OCCUPA                            | CERTIFICATE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 749451                                                                                                            |
| HY<br>f (                                            | County of the Co | 28                                                                                                                |
| E 5                                                  | City of Registration District No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Local Registrar's No. 5844                                                                                        |
| nen 'X,                                              | Primary Registration District                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | No. 216                                                                                                           |
| · E H E                                              | (If death occurred in a hospital or institution, give its                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ony varpeles                                                                                                      |
| ORD<br>CACTL<br>statem                               | (if death occurred in a nospital or insertation, give its                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | n/O                                                                                                               |
| ă E z                                                | 2. FULL NAME of the contract o | ey                                                                                                                |
| r R<br>Exa                                           | (a) Residence. Na 320 11. Grant                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | St                                                                                                                |
| st ST                                                | (Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.                |
| NG<br>PERMANENT<br>hould be state<br>y classified. F | DEDGOMAL AND OF ANTONICAL DADRECTH ADC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | MEDICAL CERTIFICATE OF DEATH                                                                                      |
| ING<br>PERMAN<br>should be<br>ly classified          | PERSONAL AND STATISTICAL PARTICULARS  8. SEX 4. COLOR OF RACE 5. Single, Married, Widowed,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 16. DATE OF DEATH                                                                                                 |
| Par Se                                               | 8. SEX 4. COLOR OW RACE 5. Single, Married, Widowed, or Divorced (write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | dine 12 030                                                                                                       |
| P P P P                                              | may white                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (Month) (Day) (Year)                                                                                              |
|                                                      | 5a. If married, widowed, or divorced<br>HUSBAND of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 17 I HEREBY CERTIFY, That I attended deceased from                                                                |
| BIN<br>IS IS C                                       | (or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | June 19 1030 no time 12 10 30                                                                                     |
| R 1<br>IIS<br>IIS<br>be p                            | 6. DATE OF BIRTH (month, day and year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | that I last saw it a slive on 12 19 3                                                                             |
| FOR 1<br>THIS<br>ed. 4<br>iy be 1                    | 7. AGY Years Month Days If LESS than 1 day,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | and that death occurred, on the date stated above, at 3 m.                                                        |
|                                                      | Still Rown hrs. or min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | The CAUSE OF DEATH* was as follows:                                                                               |
| EVE<br>INK<br>supp<br>it r                           | 8. OCCUPATION OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                   |
| <b>–</b>                                             | (a) Trade, profession, or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Sulf from                                                                                                         |
| SES<br>SINC<br>sfull<br>of th                        | particular kind of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | V                                                                                                                 |
|                                                      | (b) General nature of industry,<br>business, or establishment in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (duration) yrs. mos. / ds.                                                                                        |
| NFA<br>NFA<br>NFA<br>Ca<br>ma,                       | which employed (or employer)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CONTRIBUTOR Comming wither                                                                                        |
| ARC<br>U De ter                                      | (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Secondary)                                                                                                       |
|                                                      | 9. BIRTHPLACE (city or town) President                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (duration)yrsl _mosds.                                                                                            |
| NLY, WITH ation should I'H in plain instruction      | (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 18. Where was disease contracted if not at place of death?                                                        |
|                                                      | 10. NAME OF FATHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Did an operation precede death? Date of                                                                           |
| PLAINLY<br>nformation<br>DEATH i                     | fiM. Cullen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Was there an autopsy?                                                                                             |
| SE ST SE                                             | 2) 11. BIRTHPLACE OF FATHER (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | What test confirmed diagnosis?                                                                                    |
| PLAI<br>Iforma<br>DEA7<br>See                        | (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (Signed) WIWI D.                                                                                                  |
| E H                                                  | 12. MAIDEN NAMEOF MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6-12, 120 (Address) Tracella                                                                                      |
| WRITE<br>em of i<br>JSE OF<br>portant.               | Watere Calcolf                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | JA.                                                                                                               |
| WRITE item of in AUSE OF important.                  | 13. BIRTHPLACE OF MOTHER (etty gr.town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) |
| CA it                                                | (State or Coupley)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                       |
| - P - N                                              | 14. Informant J. M. Culley                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 19. Place of Burial, Cremation, or Removal                                                                        |
| 864<br>-Ever<br>state<br>is ver                      | (Address) 3no N. Jacob                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Manutaria / seco flue 1 100                                                                                       |
| _ \                                                  | 15 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 20 Undertaker Mussly Address                                                                                      |
| - ⊗<br>F. B. ION                                     | Filed / , 19.3 Q Registrar &                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Ochmiseky I Cu                                                                                                    |
| ZTE                                                  | The state of the s |                                                                                                                   |
|                                                      | <b>→</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ~                                                                                                                 |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia: Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs. meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.: Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inantion," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident: Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

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PLACE OF BIRTH <9/ STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF TITAL STATISTICS 5 ch ave - Br. CERTIFICATE OF BIRTH Registration District No......State File No..... thony TE RETURN (If born in hospital or institution Prim. Registration District No...............................Local Registrar's No. 11.11. give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of shild) Number Twin Date of Legiti-Sex of . Triplet in order SEPARAJ in order of hirth mate? Child or other? (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead.......Stillborn FULL MOTHER FATHER MAIDEN TIII'S NAME ..... Residence (Usual place of abode) 2 43 hg 5th WResidence (Usual place of abode) 2 43 (Ro. 5th Uu If non-resident, give place and State..... It non-resident, give place and State Color or race Me 9 NO Age at last Birthday Color or race. As and Age at last Birthday. Ha Birthplace (City and State or County O(City and State or County) Occupation / Yauseu ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) ..... \*Where there was no attending physician? or midwife, then the father, householder, (Physician of midwife) etc., should make this return. A stillborn child is one that neither breathes nor Address ..... shows other evidence of life after birth.

trading delivery and the old maintain tractice it. Crists have been a wheeler The same used to provent (relatively) to prove to the terms of the same of the ment of the section and the inches propert with JIOINILLE. he was too with state HALL THE about the state of A debated by the second Annual State Property State St michiganti wa laster design to the least of th where I tell to the All and All and the Al Partenhees Trees action with the THE PROPERTY OF LAMPS AND THE PARTY OF THE PARTY. Lawy welly that Lattended the birth of this child, who was the falling Dollar Pittle allering with was some fourthers. chieved antenna place of the physician Life white so astale will or the wife, went the turber, housebolder. grodiffs to hande the bloods after

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|                                                  | JUN 12 1930 DEPARTMENT OF PUBL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | IC WELFARE DO NOT WRITE IN THIS SPACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| AN AN                                            | PLACE-OF DEATH BUREAU OF VITAL S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TATISTICS State File No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| PHYSICIAN                                        | CERTIFICATE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| X X                                              | County of Registration District No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 28                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| HA                                               | City of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | No 2 / let Local Registrar's No. 58 96                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| .,                                               | (No. It Only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | honys                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| F F E                                            | (If death occurred in a hospital or institution, give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | its name instead of street and number.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| EXACTLY.<br>classified.<br>s on back.            | 2. FULL NAME I RATE CROSSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Land of the state  |
| clas<br>on                                       | (a) Residence. No. 1243 M. 5th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | St. St. State )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| in a constant                                    | (Usual place of abode.)  Length of residence in city or town where death occured. yrs. mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ds. How long in: U. S. if of foreign birth? yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| RD.<br>be stated<br>e properly o<br>instructions | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| install                                          | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the weigh)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 16. DATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                  | or Divorces (write the world)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Jane a 180                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| REC hould may Se                                 | 5a. If married, widowed, or divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| BINDING VENT RE GE shoul lat it may rtant. So    | HUSBAND of (or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| BI NE        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | , 19, 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| FOR RMA                                          | 6. DATE OF BIRTH (month, day and year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | that I last saw h alive on                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                  | 7. AGE Years Months Days of LESS than 1 day,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | and that death occurred, on the date stated above, at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ESERVEDS IS A Pully supplication term ON is ver  | The state of the s | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| ER<br>18<br>7 st<br>in t                         | 8. OCCUPATION OF DECEASED (a) Trade, profession, or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | The CAUSE OF DEATH* was an inlease:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| RES<br>IIS<br>fully<br>plai                      | particular kind of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | with with the start of the star |
| . # 2 a 5                                        | (b) General nature of industry,<br>business, or establishment in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Cha hear around                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| EGI COLO                                         | which employed (or employer)  (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | arm • -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| MARGIN<br>INK—T<br>Id be can<br>DEATH in         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (duration)yrs,mosds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| P D D D                                          | 9. BIRTHPLACE (city or town) (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CONTRIBUTORY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                  | 10. NAME OF FATHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (Secondary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| TFA<br>USE<br>eme                                | ( Xcar Cronly                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (duration) yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| State of                                         | 2 11. BIRTHPLACE OF FATHER (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 18. Where was disease contracted if not at place of death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| H g s t                                          | 11. BIRTHPLACE OF FATHER (city or town) (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Did an operation precede death? Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| E sta                                            | 12. MAIDEN NAME OF MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Was there an autopsy?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Y, Big                                           | a sector Fary sour                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What test confirmed diagnosts?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| E ₹                                              | 18. BIRTHPLACE OF MOTHER (city or town) (State or County)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (Signed) , M. D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| E PLAIR<br>Every i                               | 14.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | The state of the state of Power of Powe |
|                                                  | Informant (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 19 Prace of Burial, Cromation, or Removal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| WRITE<br>N. B.—E<br>? /8 78                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20 Undertaken                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| ¥zi €                                            | Filed III 6 19.30 Registrar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | X. J.M. Han Warnlelle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 2)                                               | <del>                                  </del>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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STATEMENT OF OCCUPATION .-- Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager." "Dealer," etc, without more precise specifications, as Day laborer. Farm laborer, Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidmic cerebrospinal meningitis"); Diptheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia"): Lobar Pneumonia; Bronchopneumonia ("pneumonia," unqualified, is indefite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of ........................ (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms: Measies: Whooping Cough: Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death). 29ds.; Bronchopneumonia (secondary). 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH No. . Registration District No...... ....State File No... (If born in hospital or institution give name.) FULL NAME OF CHILD.. (If stillborn, substitute the word "Stillbirth" for name of child) Number Twin Date of ( Legiti-Sex of in order 7 Triplet mate? 700 birth .. Child or other? (To be answered only in event of plural births) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth. (a) Born alive and now living. FULL MOTHER MAIDEN RULL NAME NAME Residence (Usual place of abode) If non-recident, give place and State It non-resident, give place and State. Le....Age at last Birthday.... Color or race What Color or race. White Age at last Birthday. 28.... (Years) Birthplace ..... Birthplace Manan (City and State or County) and State or County) Occupation / augell armer Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician? (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth.

"Reclaired and and an arranged Title Western State Committee Commit LUANTE MARCHINE TO THE MARCHINE PROPERTY OF THE PROPERTY OF TH Sunting Color Charles to server on the beneronanced of the months was need to prevent Ophthefrom Foundtorder .... the source take makes including property that the source of the start of the source of Dash Wan to I will dele . PARTURAY Unidence United States alleger A DESCRIPTION OF THE PERSON OF it con meridant, give them and itse. with the rate of the same of the same of the suprementation of the or race, or the or race, or the or race, or rac ... gordering (Que and State or exand Rate or County Gecupation ... A Water Track CHATELONTE OF ATTENDING PHYSICIAN OR MIDNIFES cells and Carrete chart sustained the bleth of this child, who was Sulficient for better differ and the (Signature) ensured those was no attending physicians Caprague in semple and er tolderte blief the fasher honbeheider. tree states the cherry A shipport non solliesed teather test was it with Address white the state of the state of the MIN. TANK

RECEIVED JUL 10-1930 PLACE OF BIRTH STATE OF IDAHO THIS IS A PERMANENT RECORD • SEPARATE RETURN must be ma DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS City CERTIFICATE OF BIRTH Registration District No. ....State File No..... orn in hospital or libstitution give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth for name of child) Twin Number Sex of Triplet Date of in order Legiti Child or other? mate 200 birth (To be rasw-red only in event of phiral births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Stillborn 💋 MAIDEN Residence (Usual place of abode) It non-resident, give place and State If non-resident, give place and State Color or race.. (Years) Birthplace ..... Birthplace ... (City and State or County) (City and State or County) CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* Born allve I hereby certify that I attended the birth of this child, who was | Stillborn on the date above stated. (Signature) .. \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Filed..

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| A.                                                                                           | -       | RECEIVED JUN 1 2 1930                                                   | STATE OF IDA                              |                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |
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| PHYSICIANS<br>of OCCUPA-                                                                     |         |                                                                         | DEPARTMENT OF PUBLI<br>BUREAU OF VITAL ST |                                                                         | DO NOT WRITE IN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | THIS SPACE                              |
|                                                                                              |         | PLACE OF DEATH                                                          | CERTIFICATE OF                            |                                                                         | State File No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 170433                                  |
| H.A.                                                                                         | C       | ounty of Bannock                                                        | Registration District No                  | - C/                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |
| it i                                                                                         | C       | ity of Pocatello                                                        | Primary Registration District             | •                                                                       | Local Registrar's                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | No. 5832                                |
| ELY<br>eme                                                                                   |         |                                                                         | (No Lynn Brothe:                          | rs Hospital                                                             | `                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         |
| Ta Constant                                                                                  |         | (If death occurred                                                      | in a hospital or institution, give its    | name instead of street and nu                                           | amber.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10                                      |
| t EX C                                                                                       | 2.      | FULL NAME Stewart I                                                     | ee England                                |                                                                         | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | R G                                     |
| ENT RECORD<br>stated EXACTLY, ]<br>d. Exact statement                                        |         | (a) Residence. No                                                       | ***************************************   |                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |
| tate                                                                                         | L       | (Usual place of abode)<br>ength of residence in city or town where dear | th occurred. yrs. mos. ds.                | How long in U. S., if of i                                              | nonresident give city or foreign birth? yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | town and State) mos. ds.                |
| DING A PERMANENT RECORD should be stated EXACTI erly classified. Exact state                 |         | PERSONAL AND STATISTICA                                                 | L PARTICULARS                             | MEDICAL                                                                 | CERTIFICATE OF DEA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                         |
| čM./<br>d b<br>assi                                                                          | 8       | . SEX 4. COLOR OR RACE                                                  | 5. Single, Married, Widowed,              | 16. DATE OF DEATH                                                       | The second secon |                                         |
| ING PERM should rly class                                                                    |         | Male White                                                              | or Divorced (write the word) Single       | Ju                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1930                                    |
| DID<br>A J                                                                                   | 5       | a. If married, widowed, or divorced<br>HUSBAND of<br>(or) WIFE of       |                                           |                                                                         | fonth) (Day)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (Year)                                  |
| BINDING<br>IS A PE<br>AGE shou<br>properly c                                                 |         | (or) WIFE of                                                            |                                           | 17 I HEREBY CERTIF                                                      | Y, That I attended decease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ed from                                 |
| FOR 1<br>THIS<br>led. A                                                                      | 6       | . DATE OF BIRTH (month, day and year)                                   | June 2, 1930.                             | that I last saw h                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | - 19 30                                 |
| FOR THIS ied.                                                                                | 7       | . 1                                                                     | Days If LESS than 1 day,                  | •                                                                       | on the date stated above, a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | t 10,209                                |
| INK—THE Supplied it may lificate.                                                            | -       | 0 0                                                                     | O min,                                    | The CAUSE OF DEATH                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | •                                       |
| <b>122</b> - 125                                                                             | 8       | . OCCUPATION OF DECEASED                                                | ,                                         | - 13lul 1                                                               | sely,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         |
| RGIN RESERVED<br>UNFADING INK—<br>be carefully supplierms, so that it man back of certifical |         | (a) Trade, profession, or particular kind of work                       | None                                      |                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | *************************************** |
| · ; 1 1 4 1                                                                                  |         | (b) General nature of industry,<br>business, or establishment in        | Infant                                    | ***************************************                                 | ( dans A2 )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | _                                       |
| GIN<br>NFA]<br>e car<br>ms, g                                                                |         | which employed (or employer)                                            | Intant                                    | CONTRIBUTORY                                                            | (duration)yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | mosds.                                  |
| ⋖: ~~ 0                                                                                      | -       | (c) Name of employer                                                    | None                                      | (Secondary)                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |
| MAWITH Should plain ction of                                                                 | 9       |                                                                         | ocatello,                                 | 10 377                                                                  | (duration)yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                         |
| r sh ≪                                                                                       | -       | (State or country)                                                      | Idaho.                                    | 18. Where was disease of if not at place of deat                        | ontracted MO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                         |
| NLY, WITH<br>tion shoul<br>I'H in plain<br>instruction                                       |         | 10. NAME OF FATHER Jesse                                                | England                                   | Did an operation precede of                                             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         |
| PLAINLY information DEATH                                                                    | ι<br>Ω  | 11. BIRTHPLACE OF FATHER (city or                                       | own)                                      | Was there an autopsy?                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0                                       |
| PL See See                                                                                   | ENT     | (State or Country)                                                      | Moreland, Idaho.                          | What test confirmed diagram, (Signed)                                   | W. Terr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ~ "                                     |
| re<br>OF<br>int.                                                                             | PARENTS | 12. MAIDEN NAME OF MOTHER AT                                            | itta Mitchel                              | 6/2/30.                                                                 | (Address) Pocate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ello, İda.                              |
| WRI'<br>item o<br>AUSE<br>importa                                                            |         | 18. BIRTHPLACE OF MOTHER (city or                                       | town)                                     | *State the DISEASE CA                                                   | USING DEATH, or in dec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | aths from VIOLENT                       |
| in in                                                                                        |         | (State or Country) Am                                                   | mon, Idaho.                               | *State the DISEASE CA<br>CAUSES, state (1) MEA<br>whether ACCIDENTAL, S | NS AND NATURE OF<br>SUICIDAL, or HOMICIDA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | INJURY, and (2)                         |
| -Every i<br>state CA<br>s very i                                                             | 14      | L Informant Jesse Engla                                                 | .nd                                       | 19. Place of Burial, Crem                                               | ation, or Removal I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Date of Burial                          |
| -Ever<br>state<br>is very                                                                    |         | (Address) 335 North Sixth                                               | Ave. Poca., Ida.                          | Ammon,                                                                  | Idaho.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 5/3/30. <sup>19</sup>                   |
|                                                                                              | 18      | Filed 6/2/30. 19                                                        | 1 BUM                                     | 20. Undertaker<br>Arthur                                                | A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Address                                 |
| hould<br>TION                                                                                | 1       | Flied, 19                                                               | Registrar                                 | AF UHUL                                                                 | w. nall Po                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ocatello                                |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile **Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs. use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Stall," "The stall age," "The "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis." etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head—homicide: Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

و الا معمدة STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of. BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH State File No. 181899 Registration District No..... (If born in hospital or institution Prim Registration District No. Local Registrar's No. give name.) alberta. FULL NAME OF CHILD.... (If stillborn, substitute the word "Stillbirth" for name of child) Number Twin Date of Legitiand in order Sex of Triplet mate? & of birth Child (Month) (Day) (To be answered only in event of plural births) What prophylactic was used to prevent Ophthalmia Neonatorum? Number ofichild of this mother, including present birth. Born alive and now living.... Born alive but now dead Stilborn FIII.I. MAIDEN FULL NAME Residence (Usual place of abode If non-resident, give place and Stat It non-resident, give 619 Color or race. Color or race. Birthplace ..... Birthplace ... (City and State or County) (Cft and State or County) Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR KIDWIFE. I hereby certify that I attended the birth of this child, who was stillbe on the date above stated. (Signature) ...... \*Where there was no attending physician? (valcian or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor Address/ shows other evidence of life after birth. Filed. Registrar.

THE PRINT De later thought the Later and The Marie Marie Marie Programme and the Marie of No. 2. of the senset of the word will be mane of the Critical lettels between or when between the and the state of the provent Ophobalasta Neoneth alast BOYN CHECKING CONT. Register | Level plant of the b. .. If non-seculous also read for the second li A Tolor of TROM ecity and State or County) 2012 Partie Overing Hell State Tely surry 9 CHECKEN OF ATTENDED JUNEAU OR STOWITH OF THE PERSON ! hands that's the strended the birth of this wild, one see stillborn (Sixualure) "Reinstill was no streading physicians." ("Velician or midwiel") confidence the Miles menetolier. sin, should meets this return. A stillhorn Address: child in one that netther breasnes nor shows Maer evidence of life after birth. E bully

| A-A                                                           | RECEIVED JUL 5 1930 STATE OF IDA                                                        | но                                                                                                                                                            |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>A</b> E I                                                  | DEPARTMENT OF PUBLI                                                                     | DO NOT WHILE IN THIS STACE                                                                                                                                    |
| PHYSICIA                                                      | -PLACE F DEATH BUREAU OF VITAL ST                                                       | حریست حرح بیشت                                                                                                                                                |
|                                                               | County of Certificate OF                                                                | DEATH State File No                                                                                                                                           |
| 7 D                                                           | City of Jessepatron Registration District No                                            | Local Registrar's No                                                                                                                                          |
| A,Y, l                                                        | Primary Registration District                                                           | No. 7. 0                                                                                                                                                      |
| RECORD<br>EXACTLY,<br>act statemer                            | (No                                                                                     | name instead of street and number.)                                                                                                                           |
| KA(                                                           | 1 Pol Carlo File                                                                        | birth                                                                                                                                                         |
| r RECORD ed EXACT Exact state                                 | 2. FULL NAME                                                                            | h.,                                                                                                                                                           |
| 7.7                                                           | (a) Residence. No                                                                       | St. (If nonresident give city or town and State)                                                                                                              |
| EN<br>sta                                                     | Length of residence in city or town where death occurred. yrs. mos. ds.                 | How long in U. S., if of foreign birth? yrs. mos. ds.                                                                                                         |
| NG<br>PERMANENT<br>hould be state<br>y classified. E          | PERSONAL AND STATISTICAL PARTICULARS                                                    | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |
| RM<br>Id I                                                    | 3. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)       | 16. DATE OF DEATH                                                                                                                                             |
| NG<br>PERI<br>hould<br>y clar                                 | Thate The Joyann                                                                        | (Month) (Day) (Year)                                                                                                                                          |
| A S. L.                                                       | 5a. If married, widowed, or divorced HUSBAND of                                         | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                           |
| BIND<br>IS A<br>AGE<br>proper                                 | (or) WIFE of                                                                            | 19                                                                                                                                                            |
|                                                               | 6. DATE OF BIRTH (month, day and year)                                                  | that I last saw h alive on, 19                                                                                                                                |
| FOR THIS lied.                                                | 7. AGE Yers More Days If LESS than 1 day,                                               | and that death occurred, on the date stated above, atm.                                                                                                       |
| ED FC<br>K—TH<br>pplied<br>may<br>icate.                      | min,                                                                                    | The CAUSE OF DEATH was an follows:                                                                                                                            |
| ESERVED ING INK-ully supplithat it m that it m for certifical | 8. OCCUPATION OF DECEASES                                                               | Tristerment of delivery of Moller                                                                                                                             |
| SEI<br>IG<br>Phat                                             | (a) Trade, profession, or Stell - Com Jufant                                            | ( the Born chife)                                                                                                                                             |
| RES<br>DIN<br>efull<br>so th                                  | (b) General nature of industry.                                                         |                                                                                                                                                               |
|                                                               | business, or establishment in which employed (or employer)                              | (duration)yrsmosds.                                                                                                                                           |
| RGIN<br>UNF<br>be c<br>erms                                   | (c) Name of employer                                                                    | CONTRIBUTORY (Secondary)                                                                                                                                      |
| MAR<br>H U<br>Id b<br>n te                                    | Leogrlown Ala                                                                           |                                                                                                                                                               |
| WITH<br>WITH<br>should<br>plain<br>ction                      | 9. BIRTHPLACE (city or town) (State or country)                                         | 18. Where was disease contracted if not at place of death?                                                                                                    |
|                                                               | 10. NAME OF FATHER O                                                                    | Did an operation precede death? Date of                                                                                                                       |
| PLAINLY<br>nformation<br>DEATH i                              | Maron C. Care                                                                           | Was there an autopsy?                                                                                                                                         |
| PLAIN<br>forma<br>DEAT<br>See                                 | 2 11. BIRTHPLACE OF FATHER Opity or town)                                               | What test confirmed diagnosis?                                                                                                                                |
| PL DE S                                                       | 11. BIRTHPLACE OF FATHER Lity or town (State or Country)  12. MAIDEN NAME OF MOTHER (1) | (Signed) M. D.                                                                                                                                                |
| refright                                                      | A 12. MAIDEN NAME OF MOTHER OIL : P. 340                                                | (Address) Augstus                                                                                                                                             |
| WRITE<br>m of i<br>ISE OF                                     | Court one of                                                                            | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT                                                                                                   |
| WRITE<br>item of i<br>AUSE OF<br>important.                   | 13. BIRTHPLACE OF MOTHER (city of town) (State or Company)                              | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| >° C > .                                                      | 14. VII. & 10/07/5                                                                      | 19. Place of Burial, Cremation, or Removal   Wate of Burial                                                                                                   |
| -Every<br>state (                                             | Informant                                                                               | Leggatown Jan Jan 11 1930                                                                                                                                     |
| \ <del></del>                                                 | (Address) Jeong chron                                                                   | 20. Undertaker/ Address                                                                                                                                       |
| Origina                                                       | 15. Filed /30/, 1934/                                                                   | matter will kongeton                                                                                                                                          |
| z e E                                                         | Refistrar                                                                               |                                                                                                                                                               |

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HOMICIDAL, or as probably such, if impossible to de-

termine definitely. Examples: Accidental drowning;

struck by railway train-accident; Revolver wound of

head-homicide; Poisoned by carbolic acid-probably sui-

cide. The nature of the injury, as fractured skull, and con-

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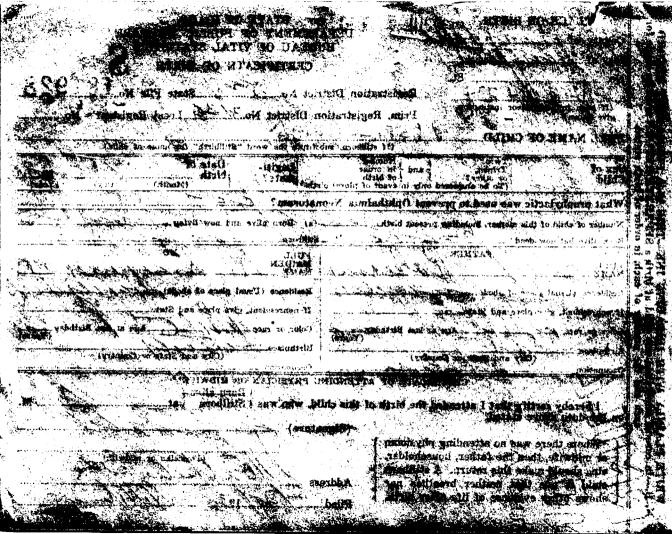
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midwife.

head of "Contributory."

RECORD be made for STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH PERMANENT I RETURN must b th stated. 181928 Registration District No.... State File No. (If born in hospital or institution Prim. Registration District No. 2/36 Local Registrar's No. give name.) STILLBORN FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Number Date of Sex of Legitiz in order Triplet and birth Child ' or other? mate? (Month) (Dav) (Year (To be answered only in event of plural births) What prophylactic was used to prevent Ophthalmia Neonatorum? 🕹 Number of child of this mother, including present birth. -(a) Born alive and now living. Born slive but now dead... Stillborn FATHER FULL MAIDEN FULL NAME \_\_\_\_ Residence (Usual place of abode) Residence (Usual plage of abode) If nonresident, give plane and State If nonresident, give place and State Age at tast Birthdas Age at last Birthday Color or race (Years) Birthplace . Birthplace. (City and State or Country) (City and State or Country) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIPE I hereby certify that I attended the birth of this child, who was & Stillborn PLAINLY on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, Physician or midwile) WRITE B—In c etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth. ż



STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE RECEIVE DENTE BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH State File No...... County of 1/10 Registration District No... Local Registrar's No. Primary Registration District No. EXACTLY. PERMANENT RECORD or institution, give its name instead of street and number.) 2. FULL NAME. (a) Residence. No..... (If nonresident give city or town and State) (Usual place of abode) How long in U. S., if of foreign birth? Length of residence in city or town where death occurred. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 5. Single Married, Widowed. 16. DATE OF DEATH **Phould** (Month) If married, widowed, or divorced HUSBAND of 17. I HEREBY CERTIFY. That I attended deceased from (or) WIFE of \_\_\_\_\_, 19\_\_\_\_\_, to\_\_\_\_\_\_, 19\_\_\_\_\_, 19\_\_\_\_\_ 6. DATE OF BIRTH (month, day and year) that I last saw h..... Months Days If LESS than 1 day, and that death occurred, on the date stated above. at..... ....hrs. or 8. OCCUPATION OF DECEASE (a) Trade, profession, or particular kind of work..... (b) General nature of industry business, or establishment in which employed (or employer) CONTRIBUTORY (c) Name of employer (Secondary) duration) \_\_\_\_\_yrs. \_\_\_\_mos. BIRTHPLACE (city or town 18. Where was discase contracted (State or country) if not at place of death Did an operation procede death: Was there an autorsy? 11. BIRTHPLACE OF FATHER What test confirmed diagnosis (State or Country) 12. MAIDEN NAME OF MOTHER \*State the DISEASE CAUSING BEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICOAL. 18. BIRTHPLACE OF MOTHER city or town (State or Country Date of Burial 19.7 Place of Burial, Cremation, or Removal Informant (Address Registrar

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| orkin<br>e made                                                  | County of the first of the firs | STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| must b                                                           | No St St Registration D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | CERTIFICATE OF BIRTH  181961  District No. 22 State File No.           |
| HIS IS A FERMANEN<br>SEPARATE REFURN<br>In order of birth stated | FULL NAME OF CHILD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | substitute the word "Stillbirth" for name of child)                    |
| ARATE<br>ler of bi                                               | Sex of Child Twin Triplet or other? And In order of birth (To be answered only in event of plural bir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        |
| Ord<br>Ord                                                       | What prophylactic was used to prevent Ophthalm                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |
| - 8                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | th. (a) Born alive and now living.                                     |
| birth<br>each                                                    | Born alive but now dead.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |
| at bin                                                           | FULL Floyd Thompson.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | FULL MAIDEN Colith Turniss.                                            |
| child                                                            | Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Residence (Usual place of abode)                                       |
| 2 d a                                                            | It non-resident, give place and State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | If non-resident, give place and States                                 |
| the n                                                            | Color or race White Age at last Birthday 36 Birthplace Gano (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 8) Birthplace (Years)                                                  |
| than<br>than                                                     | (City and State or County)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (City and State or County)                                             |
| ≥ ຄ ້                                                            | Occupation CERTIFICATE OF ATTENL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | DING PHYSICIAN OR MIDWIFE.                                             |
| of more                                                          | I hereby certify that I attended the birth of the on the date above stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Born-alive                                                             |
| PLA<br>Gase<br>f                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (Signature) CUBUK                                                      |
| WELLE<br>B.—In c                                                 | *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Address Black L. C.                                                    |
| z.                                                               | shows other evidence of life after birth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Filed July 2 19 10 / Lalens aline Registrar.                           |

MARIE TILLERARD CHE PROPERTY OF A Prim Registry Mon District Marie 2 Today of algebrain sportling the THE THE PARTY OF Company of the city of the Company o where prophylately the used to present Ophthalinia Sugmentantial and the spirit this more and the control of the party of the property of the party Stillborn heat will but and heat . YMAY Reldence Unal place of whole was the relief Marginer Clause where the same li man-recident, give place and the same of th Color or tace. Cooks or me, v. Cooks at unt Brinday .... sonigetiniff (Vity that State or County) (The and Make de County) Geeuparion ..... CHAPTERICATE, OF ATTENDED PHYSICIAN OF MARKET Cancelly course that I strended the birth of this child, who was South we the date along the ter-COLUMN TO STATE OF STREET for there there was no attending physician : or nudwife, then the father, benefit older. ofe, should make this return. A stillborn and the sac that religion blanches at all the mild refle all le anna les birth.

STATE OF IDAHO RECEIVED JUL 7 DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH State File No..... CERTIFICATE OF DEATH Registration District No.... Local Registrar's No. Exact statement Primary Registration District No. 2191 EXACTLY (M-death occurred in a hospital or institution, give its name instead of street and number.) (a) Residence, No..... (Usual place of abode) (If nonresident give city or town and State) Length of residence in city or town where death occurred. How long in U. S., if of foreign birth? yrs. mos. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 3. SEX Single, Married, Widowed. should or Divorced (write the word) 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of 6. DATE OF BIRTH (month, day and year) that I last saw h\_\_\_\_\_ alive on... 7. AGE and that death occurred, on the date stated above, at The CAUSE OF DEATH\* was as follows: min. 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry. business, or establishment in (duration) \_\_\_\_yrs. \_\_\_mos. which employed (or employer) CONTRIBUTORY (c) Name of employer (Secondary) (duration) \_\_\_\_\_yrs. \_\_\_\_mos. \_\_\_\_ds plain 9. BIRTHPLACE (city or town) 18. Where was disease contracted (State or country) if not at place of death? \_ 10. NAME OF FATHER OF DEATH Was there an autopsy? .... 11. BIRTHPLACE OF FATHER (city or What test confirmed diagnosis? (State or Country) 18. BIRTHPLACE OF MOTHER (city or town) \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (State or Country) Place of Burial, Cremation, or Removal Date of Burial (Address) Address Registrar

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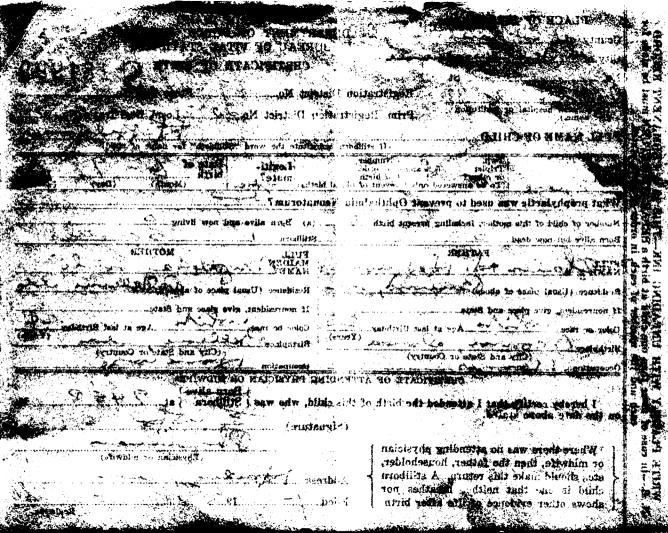
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|                             | PLACE OF BIRTH ~                                                                  | STATE OF IDAHO                    | v                       |
|-----------------------------|-----------------------------------------------------------------------------------|-----------------------------------|-------------------------|
| d fe                        | County of A SEE YED JUL 5 1830 DEPA                                               | ARTMENT OF PUBLIC                 | WELFARE -               |
| KECOKD<br>be made fo        | City of Dellerse : BI                                                             | UREAU OF VITAL STA                | ristics                 |
|                             |                                                                                   | CERTIFICATE OF BIL                | RTH C 181999            |
| 2 2                         | No                                                                                | trict No. 57 Ste                  |                         |
| Z 9                         | 956 200 007 - 39 Registration Dist                                                | rict NoSta                        | te File No              |
| RETURN must 1<br>th stated. | (If born in hospital or institution Prim. Registration                            | on District No. 20221             | logal Registrar's No.   |
| E E E                       | FULL NAME OF CHILD STILL 3                                                        | 1 nso                             | Testregues              |
| st Size                     | (If stillborn, su                                                                 | bstitute the word "Stillbirth" fo | r name of while)        |
| 고문속                         | Sex of Twin Number in order                                                       | Legiti- Date of                   | To- 9 1030              |
|                             | or other? (of birth (To be answered only in event of plural b                     |                                   | (Onth) (Day) (Year)     |
| ARA's                       | What prophylactic was used to prevent Ophthalmia Neo                              | natorum ?                         |                         |
| P P E                       | Number of child of this mother, including present birth                           | (a) Born alive and now livin      | , 0                     |
| SEP.                        | Born alive but now dead 🗢                                                         | Stillborn !                       | 5 months                |
| A 8.E                       | FATHER \                                                                          | FULL 0                            | MOTHER P. 0             |
| 무단성                         | NAME harles to Hestell ger                                                        | MAIDEN Muxtle 7                   | ay file                 |
| S to to                     | Residence (Usual place of abox)                                                   | Residence (Usual place of all     | Alelerone, elda         |
|                             | If nonresident, give place and State                                              | If nonresident, give place and    | State                   |
| 돌등골                         | Color or race Age at last Birthday 25                                             | Color or race                     | Age at last Birthday 24 |
| ONFADI<br>one child         | (Years)                                                                           | Birthplace Sellen                 | (Years)                 |
| H = 9                       | (City and State or Country)                                                       | (City and                         | State or Country)       |
| WITH<br>than c<br>nd the    | Occupation CERTIFICATE OF ATTENDIN                                                | Occupation OR MIDWIES             |                         |
| LY W<br>more t              | CERTIFICATE OF ATTENDIT                                                           | Born slive                        | _                       |
| P i C                       | I hereby certify that I attended the birth of this ch                             | ild, who was \Stillborn \         | at 7 45 P. M.           |
| اتة يب•⊵                    | on the date above stated. (Sign                                                   | nature)                           | ्रिक                    |
| PLAI                        |                                                                                   | Ohna                              |                         |
|                             | *Where there was no attending physician or midwife, then the father, householder, | (Phys                             | cian or midwife)        |
| H H                         | etc., should make this return. A stillborn                                        | Harlen                            | ر مام                   |
| B. B.                       | child is one that neither breathes nor                                            | 7 3 3                             | Pot 111111              |
| Ż                           | shows other evidence of life after birth. Filed                                   | / - / 1920 V                      | Registrar.              |
|                             |                                                                                   | 1                                 | /Lickistral.            |



| A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | RECEIVED JUL 5 1920 STATE OF II                                                            | АНО                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
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| <b>₹</b> ₽                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | DEPARTMENT OF PUB                                                                          | LIC WELFARE DO NOT WRITE IN THIS SPACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 55                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | PLACE OF DEATH BUREAU OF VITAL                                                             | STATISTICS THE STATE OF THE STA |
| PHYSICIAN<br>of OCCUPA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | County of Certificate O                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| H,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Registration District No                                                                   | 57                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | City of .U. Primary Registration Distr                                                     | ct No. 2012 Local Registrar's No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| NENT RECORD stated EXACTLY, ed. Exact statemen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| RECORD<br>  EXACTL<br>  ract statem                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (No(If death occurred in a hospital or institution, give                                   | ts name instead of street and number.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| MA K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                            | $\gamma$                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| r REC<br>ed EX<br>Exact                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2. FULL NAME                                                                               | Los Area S.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| i eğ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (a) Residence. No                                                                          | St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| E ta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Usual place of abode) Length of residence in city or town where death occurred. yrs. mos. | (If nonresident give city or town and State) is. How long in U. S., if of foreign birth? yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| NG<br>PERMANENT<br>nould be state<br>g classified. E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | PERSONAL AND STATISTICAL PARTICULARS                                                       | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| MA<br>P BSij                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | # SEX 4. COLOR OR RACE 5. Single, Married, Widowed,                                        | 16. DATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| PERN<br>PERN<br>hould<br>y clas                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | or Divorced (write the word)                                                               | The Date of Death C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Jensey Sweet James                                                                         | (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| BINDIN<br>IS A I<br>AGE sh<br>properly                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 5a. If married, widowed, or divorced HUSBAND of                                            | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| IS AGE prope                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (or) WIFE of                                                                               | <u> </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| SAG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. DATE OF BIRTH (month, day and year)                                                     | 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| rOK<br>rHIS<br>sd. 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 7. AGE Years Months Days If LESS than 1 day                                                | that I last saw h alive on 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Ot 50 d Tomo feture                                                                        | and that death occurred, on the date stated above, at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ED<br>KK—<br>ppli<br>ma<br>jeate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | To the min.                                                                                | The CAUSE OF DEATH was as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 8. OCCUPATION OF DECEASED                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| E Paris                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (a) Trade, profession, or particular kind of work                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| of the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (b) General nature of industry,                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| FAI<br>Care<br>S, 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | business, or establishment in which employed (or employer)                                 | (duration) ,yrsmosds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Para la se de a se de la se de | 1                                                                                          | CONTRIBUTORY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| ter d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (c) Name of employer                                                                       | (Secondary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| WITH<br>WITH<br>should<br>plain<br>ction                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 9. BIRTHPLACE (city or town) Jellenny                                                      | (duration)yrsmosds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| WITH<br>WITH<br>should<br>plain<br>ction                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (State or country)                                                                         | 18. Where was disease contracted if not at place of death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NAME OF FATHER                                                                             | Did an operation precede death Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Inst                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Charles H. Hettely ger                                                                     | Was there an autopsy?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 11. BIRTHPLACE OF FATHER (city or town)                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| LAI<br>form<br>See                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 11. BIRTHPLACE OF FATHER (city of town)  (State of Country)  12. MANDEN NAME OF MOTHER     | What test confirmed diagnosis?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| T. I. I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | to way and an women                                                                        | (Signed) , M. D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| of of trant                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A 12. MADEN NAME OF MOTHER                                                                 | , 19 3 (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| WRITE<br>m of i<br>ISE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 18. BIRTHPLACE OF MOTHER (city of own)                                                     | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| WRI<br>y item o<br>CAUSE<br>y imports                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (State or Country)                                                                         | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 20.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 14. MALCH AT OA                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Every<br>state (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Informan I Informan                                                                        | Place of Burial, Cremation, or Removal Date of Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Ever<br>state                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (Address) Sellevie Jack                                                                    | ( Gellene, ella 10 193.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| SEZ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 15. 7-1 20 PATITION                                                                        | 20. Undertaker Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| Z.E.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Try tou at                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

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DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

PLACE OFFICE VED JUL 5 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH No. Registration District No. (If born in hospital or institution Prim. Registration District No.2 / 25 Local Registrar's No. give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Number Date of Sex of Legiti-Triplet in order Child or other? birth mate? (To be answered only in event of plural births) (Month) (Dav) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth...... (a) Born alive and now living..... Born alive but now dead......Stillborn ..... FULL 6 MOTHER MAIDEN It non-resident, give place and SQte. If non-resident, give place and Color or race... Birthplace ...... (City and State or County) Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder. (Physician or-midwife)etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

OHAR SO STATE BEATLEST OF BOSIC WELLARD Lough of the Part POTELTATE OF PERSON STATISTICS HTHIR TO STREET Registration Charlet Co. The second of th the sultime sandartine the word "children" for name of salid. Norman (16 Manufact) other world of plant themel (Month) (Par) (Feer) had promised was used to present Ophthaluta Reconstruction? denimber of this method line inches line in the method by the site and new living Rithbora Rord will's but now doed. The state to make tour! I marking ! Rodfing Kanning are at about 1 Care at 1 de una resident, cire talera Credit Law agels were to describe Color or page at the street of the street Age at last Pirtheau Birthbace (CIES MAN STREET OF COMMENT) antiegrone : CHARTESONTR OF ATTENDED PHYSICIAL OF READERTHE Landing merities that I attended the hirth of this child, who was I COLUMN SERVE SERVE STATES (Signatory) There there was all attending physicians The second to ald wife, then the facilet flourehander. etc., shaple and the returns, a stallbot a TOO SECTION SECTION AND SECTION Strict total will to made 175 will swall.

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| County of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Bonner<br>Ouse Creek, s                                       |                             | FICATE OF                   | 76                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | State File No                                                | 7.2                                                         |
| 2. FULL N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | AMEStill                                                      | (Nourred in a hospital or i | institution, give its       | name instead of street an                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                              | you                                                         |
| Length of resid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | place of abode)<br>lence in city or town where                | death occurred.             | s. mos. ds                  | How long in U. S., if                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                              | yrs. mos. ds.                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | PERSONAL AND STATIS                                           |                             |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CAL CERTIFICATE O                                            | F DEATH                                                     |
| (a) Res<br>(Usual<br>Length of residence of the second of the se |                                                               | or Divoteed (w              | rite the word)              | 16. DATE OF DEA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | me 9                                                         | (Day) (Year)                                                |
| 5a. If married<br>HUSBA<br>(or) W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | IFE of                                                        | 1                           | 1930                        | 17. I HEREBY CER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | - 11, 4                                                      | ng 9, 193                                                   |
| 6. DATE OF 7. AGE 8. OCCUPAT (a) Trade particular                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | BIRTH (month, day and years Months                            | ar)                         | ESS than 1 day, hrs. or     | II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ed, on the date stated al                                    | bove, at 5:30 7.                                            |
| 8. OCCUPAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ON OF DECEASED                                                |                             | min,                        | A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                              |                                                             |
| (a) Trade particular                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | profession, or<br>sind of work                                |                             |                             | Still fint                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | h . 8 /2                                                     | - monch                                                     |
| (b) General business, o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | al nature of industry, r establishment in loyed (or employer) |                             |                             | Joetus.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                              | yrsmosd                                                     |
| (a) Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | of employer                                                   |                             |                             | CONTRIBUTORY<br>(Secondary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                             |
| _ 🔍                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ACE (city or town)                                            | ouse Creek                  | k                           | 18. Where was discs if not at place of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | use contracted                                               | mosd                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OF FATHER                                                     | 00 class                    |                             | 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | cede death? 20 D                                             | ate of                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | IPLACE OF FATHER (cit<br>or Country)                          | y or town)                  |                             | Was there an autops What test confirmed (Signed)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                              | Tules 1                                                     |
| THE STATE OF       | EN NAME OF MOTHER                                             |                             | Bonny                       | June 10, 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 930 (Address) Sa                                             | napoint, do                                                 |
| 13. BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | PLACE OF MOTHER (ci                                           |                             |                             | *State the DISEAS<br>CAUSES, state (1)<br>whether ACCIDENTA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | E CAUSING DEATH, o<br>MEANS AND NATUI<br>AL, SUICIDAL, or HO | r in deaths from VIOLEN<br>RE OF INJURY, and (2<br>MICIDAL. |
| 14. Informant. (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Elmer Od                                                      | ell dans                    | ran                         | 19. Place of Burial,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Cremation, or Removal                                        | Date of Burial June 10 195                                  |
| (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 10 10 1030                                                    | Viola C                     | Ellen                       | 20. Undertaker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Bosson                                                       | Address Squelfornil                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                               | Wefrety                     | Registrar                   | The service of the se | V SWELLING )                                                 | (Mulal)                                                     |

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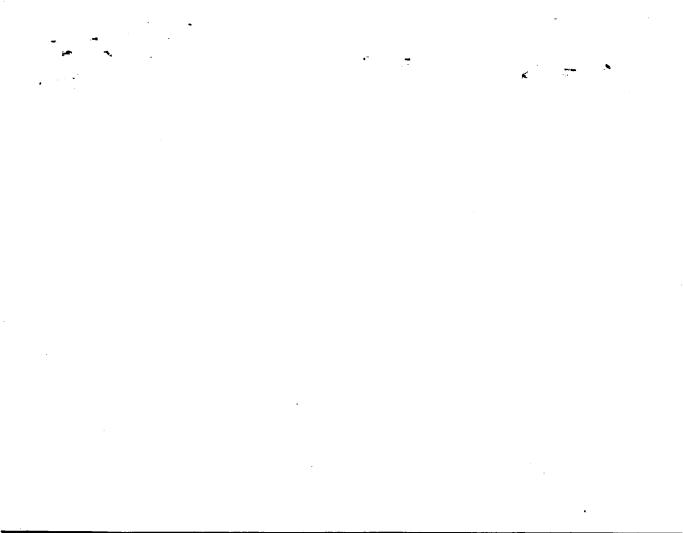
Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

| F                                 | PLACEDIERTH JUL 1 0 1930 STATE OF ID                                              | AHO ~~                                    | 7        |
|-----------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------|----------|
| £.                                | County of Boundarille DEPARTMENT OF PUB                                           | LIC WELFARE                               | •        |
| ÖŽ                                | City of Dolaho Falls BUREAU OF VITAL                                              | STATISTICS                                | ,        |
| RECORD<br>be made for             | CERTIFICATE OF                                                                    | BIRTH                                     |          |
| <b>2</b> ,22                      | No St.                                                                            | 18202                                     | 6        |
| ENT                               | 25/129 010-285 Registration District No. 13                                       | State File No                             |          |
| 图音                                | (If born in hospital or institution give name.)  Prim. Registration District No/  | Production v 0                            | 39       |
| ERMANENT<br>STURN must<br>stated. | Z-                                                                                | Local Registrar's No                      |          |
| ERMAN<br>ETURN<br>stated.         | 52 FULL NAME OF CHILD.                                                            | ***************************************   |          |
| 西西部                               | (Turin ) (Name how                                                                |                                           |          |
| <b>PK</b> 5                       | Sex of Triplet and in order Legiti-                                               | $e^{\text{of}} \mathcal{H} - 29 - \cdots$ | 2~       |
|                                   | (To be answered only in event of plural births)                                   | (Month) (Day) (Year                       | I) _     |
| RA.                               | What prophylactic was used to prevent Ophthalmia Neonatorum?                      | surol Soll                                | 08       |
|                                   | Number of child of this mother, including present birth 4 (a) Born alive and flow | 3                                         |          |
| SE                                | · [4] 5                                                                           | living S                                  |          |
| J 8 .5                            | SA DITTOR                                                                         | MOTHER                                    |          |
| Z t t                             | Je FULL MAIDEN                                                                    | MOTHER                                    |          |
| ea bit.                           | 8.0                                                                               | re spend                                  |          |
| S # E                             | Residence (Usual place of abode)                                                  | of abode). Saho fall                      | R        |
| FAD<br>child<br>nber              | If nonresident, give place and State If nonresident, give place                   | e and State                               |          |
| 돌중설                               | E Color or race Africa Age at last Birthday 29 Color or race                      | Age at last Birthday 2                    | フ        |
|                                   | Birthplace Old Fall (Years) Birthplace Old                                        |                                           | ars)     |
| le n                              | Birthplace (City and State or Country)                                            | and State or Country)                     | 7        |
| iha<br>E                          | Occupation Occupation                                                             |                                           |          |
| e t                               | CERTIFICATE OF ATTENDING PHYSICIAN OR MIDV                                        | VIFE*                                     |          |
| nor<br>h                          | I hereby certify that I attended the birth of this child, who was stilled         | at 3:00 de                                | М.       |
| of I                              | on the date above stated.                                                         | 1 00                                      |          |
|                                   |                                                                                   | any                                       |          |
| PL/<br>Case                       | *Where there was no attending physician or midwife, then the father, householder. | n.O.                                      |          |
| 2 g                               | etc., should make this return. A stillborn                                        | (Physician or midwife)                    | ,        |
| ₹T                                | child is one that neither breathes nor Address                                    | o Talk, Idah                              | 5        |
| <u>Ş</u> ¤i                       | shows other evidence of life after high                                           | 1 04 N                                    | 0        |
| z                                 | z Filed 7 1960                                                                    | Registrar                                 | <u> </u> |



| STATE OF                                                                                  |                                                                                                            |
|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| RECEIVED MAY 2 4 1930 DEPARTMENT OF PUR BUREAU OF VITAL                                   |                                                                                                            |
| " PLACE OF DEATH SEPTEMBER OF                                                             | TI DELETT                                                                                                  |
| County of Bonnevill Registration District No.                                             | State File No.                                                                                             |
| City of Ala Falls PR #7 Primary Registration Dist                                         | trict No 2/4-6 Local Registrar's No. 79                                                                    |
| (No                                                                                       | VIII A101.781.11.14                                                                                        |
| (If death occurred, in a hospital or instituti                                            | on, give its name instead instead of street and number.)                                                   |
| 2. FULL NAME (Stell / 2040) //                                                            | Mert W. Ceal.                                                                                              |
| (a) Residence. No. 6 miles A. on Moulance                                                 | Neway.                                                                                                     |
| (Usual place of afode) Length of residence in city or town where death occurred yrs. mos. | ds. How long in U. S., if of foreign birth? yrs. mos. ds.                                                  |
| PERSONAL AND STATISTICAL PARTICULARS                                                      | MEDICAL CERTIFICATE OF DEATH                                                                               |
|                                                                                           |                                                                                                            |
| 3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)            | 16 DATE OF DEATH                                                                                           |
| Thate to Baby.                                                                            | The 28                                                                                                     |
| 5a If married, widowed, or divorced                                                       | (Month) (Day) (Year)                                                                                       |
| HUSBAND of (or) WIFE of                                                                   | 17 I HEREBY CERTIFY, That I attended deceased fro                                                          |
| (67) 1172 01                                                                              | 19                                                                                                         |
| 6 DATE OF BIRTH (month, day and year)                                                     | that I last saw belokus on John. 19                                                                        |
| 7 AGE Years Months Days If LESS than                                                      | and that death occurred, on the date stated above, at                                                      |
|                                                                                           | The CAUSE OF DEATH* was as follows:                                                                        |
| 8 OCCUPATION OF DECEASED                                                                  | Till Born Premiter                                                                                         |
| (a) Trade, profession, or                                                                 |                                                                                                            |
| particular kind of work.                                                                  |                                                                                                            |
| (b) General nature of industry, business, or establishment in                             | Aduration) yrs mos                                                                                         |
| which employed (or employer)                                                              | CONTRIBUTORY Want Rnow.                                                                                    |
| (-) reality of elliphotol                                                                 | (Secondary)                                                                                                |
| 9 BIRTHPLACE (city or town) Joseph Falls.                                                 | (duration) yrs mos                                                                                         |
| (State or country)                                                                        | 18 Where was disease contracted if not at place of death?                                                  |
| 10 NAME OF FATHER                                                                         | Did an operation precede death? Date of                                                                    |
| W-W./3 cal.                                                                               | Was there an autopsy?                                                                                      |
| 11 BIRTHPLACE OF FATHER (city or town)                                                    | What test confirmed dispensels?                                                                            |
| (State or country) mellian a feel.                                                        | (Signed)                                                                                                   |
| 12 MAIDEN NAME OF MOTHER                                                                  | 4/28 , 1982 (Address)                                                                                      |
| " Jerry.                                                                                  | _  -                                                                                                       |
| 13 BIRTHPLACE OF MOTHER (city or bown) (State or country)                                 | *State the DISEASE CAUSING DEATH, or in deaths from VI<br>LENT CAUSES, state (1) MEANS AND NATURE OF INJUR |
| (Newto of Contiers) Mo.                                                                   | and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                        |
| 14 Informant wm. a. Seal.                                                                 | 19 Place of Burlal, Cremation, or Removal   Date of Burlal                                                 |
| (DIAGOTES) A d la E all. A d                                                              | 1 lal = 16 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                                              |
| H. Jaan Taks. Jaa                                                                         | Jaans raw Jaa. 7/20                                                                                        |
| 15 Filed (1) 2 / 19 3 2                                                                   | 20. Undertaker 2 Med 4 Address                                                                             |
| Registrar                                                                                 | W U. T. III Han Jasio Ta                                                                                   |

I

certificate should further state, if known, the cause of the still birth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) Spinner. (b) Cotton Mill: (a) Salesman, (b) Grocery: (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer." 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None,

STATEMENT OF CAUSE OF DEATH-Name first the DIS-EASE CAUSING DEATH (the primary affection with respect to time and causation), using aways the same accepted

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report 'Typhoid Pneumonia'); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, less definite: avoid use of "Tumor" for malignant neoplasms; Measles: Whooping cough: Chronic valvular heart disease: Chronic interstitial nephrltis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.: Bronchopneumonia (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," 'Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy." "Exhaustion." "Heart Failure." "Hemorrhage." "Inanition," "Marasmus," "Old age." "Shock. "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia." "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICID-AL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS -Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

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| r RECORD ed EXACTLY, ] Exact statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2. FULL NAME Stillbill                                              | Brother                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |
| Exa<br>Exa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (a) Residence. No                                                   |                                              | St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             |
| Z ta                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Usual place of shode) Length of residence in city or town where de | ath occurred. yrs. mos. ds.                  | (If nonresident give city or town and State How long in U. S., if of foreign birth? yrs. mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ds.                         |
| NG PERMANENT tould be state greassified.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | PERSONAL AND STATISTIC                                              | CAL PARTICULARS                              | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                             |
| MA<br>be be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 8. SEX 4. COLOR OR RACE                                             | 5. Single, Married, Widowed,                 | 16. DATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             |
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| BINDING<br>IS A PERMAI<br>AGE should be<br>properly classifi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5a. If married, widowed, or divorced                                | - Millians                                   | (Month) (Day) (Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             |
| AD A Ber                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | HUSBAND of<br>(or) WIFE of                                          |                                              | 1 I HEREBY CERTIFY, That I attended deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | _                           |
| BINI<br>IS AGE<br>prope                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (or) WIFE of                                                        |                                              | 1935, to 1935, to 1935                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 30                          |
| 70 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 6. DATE OF BIRTH (month, day and year)                              |                                              | that I last saw have on 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 30                          |
| FOR<br>THIS<br>ed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 7. AGE Years Months                                                 | If LESS than 1 day,                          | and that death occurred, on the date stated above, at 8:30                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Q</b> _m.                |
| VED FOUNTAINED FOUNTAINED IN MANAGEMENT IN M |                                                                     | min,                                         | The CAUSE OF DEATH* was as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             |
| RESERVED DING INK-efully supple that it medical control of certifical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 8. OCCUPATION OF DECEASED                                           |                                              | ) for all and 200 the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                             |
| E Pat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (a) Trade, profession, or<br>particular kind of work                |                                              | Jenesticas of the de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <u>u</u>                    |
| UNFADING be carefull erms, so the back of a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (b) General nature of industry,                                     |                                              | 727                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ks                          |
| : 5 4 4 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | business, or establishment in which employed (or employer)          |                                              | (duration) yru mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ds.                         |
| ARGIN<br>I UNF<br>I be ca<br>terms,<br>on back                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (c) Name of employer                                                |                                              | CONTRIBUTORY (Secondary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ·                           |
| <b>₩</b> ₩ 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                     |                                              | (duration)yrsmos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ds.                         |
| M. TTTH sould lain                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                     | hs Falls , Flacks                            | 18. Where was disease contracted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                             |
| E E E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (State or country)                                                  |                                              | if not at place of death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <u></u>                     |
| string X,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 10. NAME OF FATHER                                                  |                                              | Did an operation precede death? Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>₹</b> 0                  |
| PLAINLY<br>nformation<br>DEATH See inst                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 11. BIRTHPLACE OF FATHER (city o                                    | - tourn)                                     | Was there an autopsy?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                             |
| PLAI<br>form<br>DEA'<br>See                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (State or Country)                                                  | . 0.0                                        | What test confirmed diagnosis?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                             |
| .= -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (State or Country)  (State or Country)  12. MAIDEN NAME OF MOTHER   | e oklahona                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | M. D.                       |
| of in OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 12. MAIDEN NAME OF MOTHER                                           | a. Beeller                                   | , 19 (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | $\mathcal{L}_{\mathcal{L}}$ |
| WRITE<br>m of i<br>ISE OF<br>portant.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 18. BIRTHPLACE OF MOTHER (city                                      |                                              | *State the DISEASE CAUSING DEATH, or in deaths from VIO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | LENT                        |
| 12 H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (State or Country)                                                  | South Calsala                                | *State the DISEASE CAUSING DEATH, or in deaths from VIOI CAUSES, state (1) MEANS AND NATURE OF INJURY, and whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | d (2)                       |
| ~O ~                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 14. Dy W. F.                                                        |                                              | 19. Place of Burial, Cremation, or Removal Date of Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             |
| Every state (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Informant A Pest                                                    | # 0                                          | 200110                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 18 3                        |
| H SE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Address)                                                           | allo to de                                   | 20. Undertaker Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |
| Self B                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 15. Filed // t 1930 /                                               | Jen com                                      | The melle the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Feel.                       |
| Z. A. T.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                     | Regristrar                                   | The state of the s | 2 mg                        |
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Do not accept a certificate of death signed only by a midwife.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No.....State File No.... (If born in hospital or institution Pripr. Registration District No.....Local Registrar's No. 294 give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number Date of Sex of Legiti-Triplet Child or other? birth mateXL (To be answered only in event of plural hirths) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth....................... (a). Born alive and now living.... Born alive but now dead \_\_\_\_\_\_Stillborn FIII. CHIT. MAIDEN NAME .... It non-resident, give place and Stat If non-resident, give place and State Birthplace Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Registrar.

WRITE

STATE ST. OF POLICE AND ASSESSED. THE LATE OF THE LA MERCIN GO WENDY TO THE state atlon, and the left of the late of t Print Region Direct No. out southwas at another the DE OF THE PERSON PHILIPPIN COLUMN (distance) transport the law and of the miteriacy and territory to the last the last territory to Ranche of other of the resident metating alongent from Dies but non the n soith 138 ...... AL CHARLE LUU HAME I mortendant, with second Color of the Color of the Color CHANGE TO ALLES DESTRUCT Dougaston CERTIFICATION OF STEEL STORY PIEVALCEAN TOP MEDICINE Lambly well start astrodes the bise of the child, who was sufficient the production and an (Figuragila) related was no attendance planting MATE HAVE BEEN STANKED CONTROL OF THE PARTY OF THE PAR TOP TOP TOP TOP THE PROPERTY OF THE PARTY OF this asile all to enchara reflection

| T RECORD ted EXACTLY, PHYSICIANS Exact statement of OCCUPA- | PLACE OF DEATH  County of Summerle Co  City of State OF IDAI  BUREAU OF VITAL ST  CERTIFICATE OF  Registration District No  Primary Registration District  (No.  Primary Registration, give its  2. FULL NAME  (a) Residence. No  (Usual place of abode) | DEATH  No. 2100  No. 2100  Local Registrar's No. 140  name instead of street and number.)  St. (If nonresident give city or town and State)                   |
|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| NEN'<br>stat                                                | Length of residence in city or town where death occurred. yrs. mos. ds.  PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                            | How long in U. S., if of fereign birth? yrs. mos. ds.  MEDICAL CERTIFICATE OF DEATH                                                                           |
| DING A PERMANENT should be state erly classified. E         | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)                                                                                                                                                                        | 16. DATE OF DEATH July / 31                                                                                                                                   |
| BINDING<br>IS A PE<br>AGE shou                              | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                                                                                                                                                             | (Month) (Day) (Year)  17. THEREBY CERTIFY, That I attended deceased from  19.30 to 19.30                                                                      |
| OR<br>HIS<br>be 1                                           | 6. DATE OF REPH (month, day and year) 1/930 7. AGE Years Months Phys II LESS than 1 day, hrs. or                                                                                                                                                         | and that death occurred, on the date stated above, at 225 A.m.                                                                                                |
| VED FOR WENT IN WENT IN WAY IN MAY IN MAY IN MAY IN MAY     | 8. OCCUPATION OF DECEASED                                                                                                                                                                                                                                | The CAUSE OF DEATH* was as follows:                                                                                                                           |
| RESERVE<br>DING INK<br>efully support that it is            | (a) Trade, profession, or particular kind of work                                                                                                                                                                                                        | Thopsus less.                                                                                                                                                 |
| GIN<br>NFA]<br>e car<br>rms, s                              | (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer                                                                                                                                         | (duration) yrs. mos. ds.  CONTRIBUTORY (Secondary)                                                                                                            |
| _Sme_~                                                      | 9. BIRTHPLACE (city or town) John July (State or country)                                                                                                                                                                                                | (duration) yrs. mos. ds.  18. Where was disease contracted if not at place of death?                                                                          |
| 'X', 'X', 'Gn 9                                             | 10. NAME OF FATHER Jun & Tulcon                                                                                                                                                                                                                          | Did an operation precede death? Date of July 1930 Was there an autopsy?                                                                                       |
| PLAID<br>nforms<br>DEAT                                     | 11. BIRTHPLACE OF FATHER (city of town) (State of Country)  12. MAIDEN NAME OF MOTHER  12. MAIDEN NAME OF MOTHER                                                                                                                                         | What test confirmed diagnosis Charles M. D.                                                                                                                   |
| WRITE<br>em of in<br>ISE OF<br>pertant.                     | 12. MAIDEN NEWS THERY Helliams                                                                                                                                                                                                                           | , 19 (Address)                                                                                                                                                |
| WRITE<br>item of i<br>AUSE OF<br>impertant.                 | 18. BIRTHPLACE OF MOTHER Mity or town (State or Country)                                                                                                                                                                                                 | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| -Every<br>state C                                           | 14. Informant Jather (Address) Jacker Jally # 3 P.s.                                                                                                                                                                                                     | 19. Place of Burial, Cremation, or Removal Date of Burial                                                                                                     |
| N. B.—<br>should                                            | 15. Filed // 9 , 19 3 0 Werness Registrar                                                                                                                                                                                                                | 20. Undertaker  Address  Address  Accepted                                                                                                                    |

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unawite.

| S IS A PERMANENT RECORD GPARATE RETURN must be made order of birth stated. | County of County |
|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| HIS<br>SEE                                                                 | What prophylactic was used to prevent Ophthalmia Neonatorim?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| H 6 2                                                                      | Number of child of this mother, including present birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| at b                                                                       | FULL Lawrence of Byungar MEEN annie May Beasley                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| FADIN<br>e child<br>number                                                 | Residence (Usual place of abode) Residence (Usual place of abode) Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>***</b> ***                                                             | It non-resident, give place and Softe.  Color or race.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| H 5                                                                        | Birthplace Blackford Vag Birthplace Stylley Dra (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| o the                                                                      | Occupation Occupation Occupation Respect                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| PLAINLY REE of more for each                                               | I hereby certify that I attended the birth of this child, who was Stillborn at on the date above stated.  (Signature)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| WRITE I                                                                    | *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.  Address  Filed No. 25 1330 Complement.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

OHACE MOST AND REAL PROPERTY OF THE PERSON OF THE PERSO EDECAR OF TEAL STATES HENRY TO MEASURE Price Registration Butter to Carrow Received to I estilinor interest to my der entrest arouties E Legiti-\* Potuss. ( De beaningeriet ande in corne of soura total EriSiPPE What minds be the man word to movem topulation Mountained Like East. butturisher of this of this mother, including present bit in ...... [4] Base alter and now Hyl Annale state with my the front the PATHING LUIT. and the second should be seen Name of the last o Color or rane La See mrtiplane .... Occupation Letter Comments wither the CERTIFICATE OF ATTECTIONS FHYBILING ON MEDWINS A LIE TON I her get much that I attended the hier of the dilid who was Stillborn the the state of the state of Stepping (C) CHI I COM MARK BOOK BO STEERS BOOK STORY They are the series of the series Andrews of the State of the Sta etitid il pas ina; pilatase linguisse nor Shows discovered at the series betti

STATE OF IDAHO Received Jul 1920 DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No..... Local Registrar's No. Exact statement Primary Registration District No. 1.1. RECORD d EXACTLY, (If death occurred in a hospital or institution, give its name instead of street and number.) 2. FULL NAME.... (a) Residence. No..... A PERMANENT (If nonresident give city or town and State) (Usual place of abode) How long in U. S., if of foreign birth? Length of residence in city or town where death occurred. yrs. mos. yrs. mos. classified. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 16. DATE OF DEATH 5. Single, Married, Widowed or Divorced (write the word 3. SEX 5a. If married, widowed, or divorced 17. I HEREBY CERTIFY, That I attended deceased from HUSBAND of (or) WIFE of SI 6. DATE OF BIRTH (month, day and year) 7. AGE Months Days If LESS than 1 day. and that death occurred, on the date stated above, at ...... Hicate The CAUSE OF DEATH\* was as foll 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. (b) General nature of industry. business, or establishment in which employed (or employer) CONTRIBUTORY (Secondary) (c) Name of employer should plain ction 9. BIRTHPLACE (city or town) 18. Where was disease contracted if not at place of death? (State or country) Did an operation precede death? Date of. 10. NAME OF FATHER Was there an autopsy? \_ 11. BIRTHPLACE OF FATHER (city or tox What test confirme Chapposis? (State or Country) (Signed) OF \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 13. BIRTHPLACE OF MOTHER (State or Country) Place of Burial, Cremation, or Removal Date of Burial Informant (Address) Address 20. Undertaker

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spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

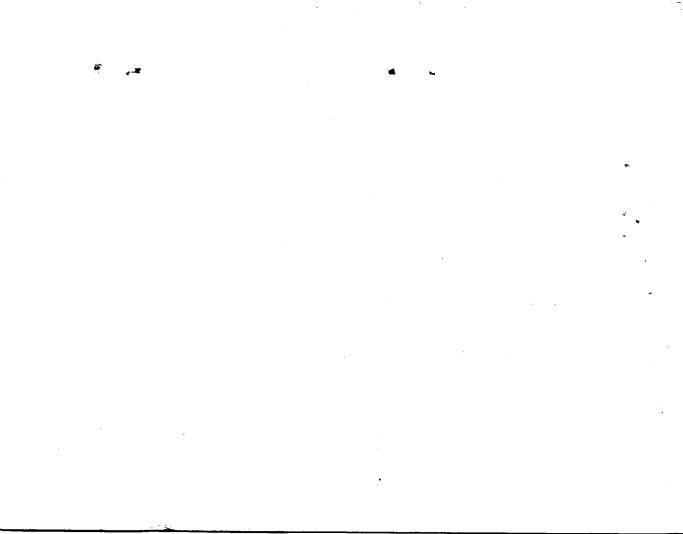
Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

| tated.     | City of Make Jalls, Ma.  No. St.  L.O.S. Marital Registration Dist  (If born in hospital or institution give name.)  FULL NAME OF CHILD Bally Lnuth                                                                                        | STATE OF IDAHO ARTMENT OF PUBLIC WELFARE UREAU OF VITAL STATISTICS  CERTIFICATE OF BIRTH trict No. 23 State File No. 182110 on District No.2 Local Registrar's No. 199  abstitute the word "Stillbirth" for name of child) |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| birth 8    | Sex of Twin And Sumber in order or other? (To be answered only in event of plural by                                                                                                                                                       | Legiti-<br>mate? Date of May 2 / 19.2-<br>(Month)/ (Day) (Year)                                                                                                                                                            |
| o          | What prophylactic was used to prevent Ophthalmia Neo                                                                                                                                                                                       | onatorum ?                                                                                                                                                                                                                 |
| der        | Number of child of this mother, including present birth                                                                                                                                                                                    | (a) Born alive and now living 4                                                                                                                                                                                            |
| 9          | Born alive but now dead                                                                                                                                                                                                                    | Stillborn                                                                                                                                                                                                                  |
| f each, ir | FATHER FULL Ben Franklin Lnilh Residence (Usual place of abode) Rive                                                                                                                                                                       | FULL MOTHER MAIDEN Sarah Morre Residence (Usual place of abode) Perce                                                                                                                                                      |
|            | If nonresident, give place and State                                                                                                                                                                                                       | If nonresident, give place and State                                                                                                                                                                                       |
| mbe        | Color or race white Age at last Birthday 3 7                                                                                                                                                                                               | Color or race Cultite Age at last Birthday 3 4                                                                                                                                                                             |
| nam        | Birthplace Cedas City, utale (Years)                                                                                                                                                                                                       | Birthplace Shelter, Idaho (Years)                                                                                                                                                                                          |
| the        | (City and State or Country)                                                                                                                                                                                                                | (City and State or Country) Occupation                                                                                                                                                                                     |
| and t      |                                                                                                                                                                                                                                            | NG PHYSICIAN OR MIDWIFE                                                                                                                                                                                                    |
| each an    | I hereby certify that I attended the birth of this ch<br>on the date above stated.  (Sign                                                                                                                                                  | aild, who was Stillborn at 6:40 M.                                                                                                                                                                                         |
|            | *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.  *Address:  Address:  Filed: | ess Schron 19 3 o Regionar.                                                                                                                                                                                                |



|                                                                           | RECEIVED                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| Ø 1                                                                       | RECEIVED JUN 20 1930 STATE OF IDAI                                                             | HO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |
| 22                                                                        | DEPARTMENT OF PUBLIC                                                                           | l l                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |
| 75                                                                        | DILIDEAU OF MINAT OF                                                                           | DO NOT WITE IN THIS STREET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
| 28                                                                        | FLACE OF DEATH                                                                                 | 70000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |
| São                                                                       | County of Bonneville CERTIFICATE OF                                                            | DEATH State File No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |
| PHYSICIANS<br>of OCCUPA-                                                  | Registration District No                                                                       | <u>) 3</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
| <b>+</b>                                                                  |                                                                                                | Tanal Dandadanania Ma / /2 /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |
| <b>5,</b> ₽                                                               |                                                                                                | NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |
| ECORD<br>EXACTLY, 1<br>of statement                                       | (No. J. D.S. Hopital                                                                           | <u> </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
| 2 5 ts                                                                    | (If death occurred in a hospital or institution, give its                                      | name instead of street and number.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |
|                                                                           | 2 FILL NAME Baby Smith                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| r RECORD<br>ed EXACT<br>Exact state                                       | 2. FULL NAME BARY SWILL                                                                        | ***************************************                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
| TO A                                                                      | (a) Residence. No                                                                              | St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |
| at A                                                                      | (Usual place of abode) Length of residence in city or town where death occurred. yrs. mos. ds. | (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |
|                                                                           | Actignity of Tollection in Say of South Financial                                              | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |
| NG<br>PERMANENT<br>Iould be state<br>7 classified. F                      | PERSONAL AND STATISTICAL PARTICULARS                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |
| GERMA)<br>uld be<br>classifi                                              | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed,                                           | 16. DATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |
| 문문문                                                                       | or Divorced (write the word)                                                                   | may 2/ 1930                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |
| ING<br>PER]<br>should<br>rly cla                                          | femile white                                                                                   | (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |
| <b>□ •</b>                                                                | Voa. If married, widowed, or divorced HUSBAND of                                               | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |
| SIS IS                                   | (or) WIFE of                                                                                   | • • • • • • • • • • • • • • • • • • • •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
|                                                                           |                                                                                                | 19 to 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
| FOR THIS ed.                                                              | 6. DATE OF BIRTH (month, day and year) way 21, 1930                                            | that I last pear hamme alive on the contraction and the contractio |  |  |
| FOR THIS ed.                                                              | 7. AGE Years Months Days If LESS than 1 day,                                                   | and that death occurred, on the date stated above, atm.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
|                                                                           | Ottillhan min.                                                                                 | The CAUSE OF DEATH* was as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |
| 园屋 高温器                                                                    |                                                                                                | Stillbon - 6 mo semelue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
| RVE<br>INK<br>sup                                                         | 8. OCCUPATION OF DECEMBED                                                                      | 41                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |
| 国の下層の                                                                     | (a) Trade, profession, or particular kind of work                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| N RESERVED FADING INK-carefully supp 8, so that it much of certifications |                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| E E E                                                                     | (b) General nature of industry,<br>business, or establishment in                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| Z Z S Z                                                                   | which employed (or employer)                                                                   | CONTRIBUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |
| RGIN<br>UNF<br>be cs<br>erms,                                             | (c) Name of employer                                                                           | (Secondary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |
| <b>-</b>                                                                  |                                                                                                | (duration)yrsmosds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |
| WITH should plain t                                                       | 9. BIRTHPLACE (city or town) Stakes Falls, Idaho                                               | (I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |
| tigh X                                                                    | (State or country)                                                                             | 18. Where was disease contracted if not at place of death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
| 7 8 1                                                                     | 10. NAME OF FATHER                                                                             | Did an operation precede death? Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
|                                                                           | Ben Lasklen Smith                                                                              | <b>!</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
| NL.) atio                                                                 | 11. BIRTHPLACE OF FATHER (city or town)                                                        | Was there an autopsy?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |
| A E \$ 8                                                                  |                                                                                                | What test confirmed diagnosis?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |
| PLAII<br>nforms<br>DEAT                                                   | (State or Country) ett. utah  12. MAIDEN NAME OF MOTHER                                        | (Signed) , M. D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |
|                                                                           | 12. MAIDEN NAME OF MOTHER                                                                      | 19 (didress)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |
| of i                                                                      | a sarah moore                                                                                  | - Jan ree 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |
| WRITE item of i                                                           | 18. BIRTHPLACE OF MOTHER (city or town)                                                        | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
|                                                                           | (State or Country)                                                                             | CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |
|                                                                           | Sheller many                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
|                                                                           | 14. Informant 13 7                                                                             | Place of Burial, Cremation, or Removal Date of Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |
| Every<br>state<br>is very                                                 |                                                                                                | Na 22/3 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
| S 7 5.8                                                                   | (Address)                                                                                      | 20. Undertaker Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
| NEW X                                                                     | 15. h. z. Sey                                                                                  | ZV. Undertaker / Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
|                                                                           | Filed 2 2 19 50 Registrar                                                                      | None _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
| ZZH                                                                       |                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

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head-homicide; Poisoned by carbolic acid-probably sui-

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sequences (e. g. sepsis, tetanus) may be stated under the

Do not accept a certificate of death signed only by a midwife.

head of "Contributory."

269106 DIO 265 STATE OF IDAHO RECORD ust be ma DEPARTMENT OF PURLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH 182134 No. Registration District No. State File No..... (If born in hospital or institution Prim. Registration District No. Local Registrar's No. 1 give name.) FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number Sex of Legiti-Date of Triplet and < in order birth .... Child or other? mate? VIA (To be answered only in event of plural births) (Month) (Day) What prophylactic was used to prevent Ophthalmia Neongtorum? MAIDEN NAME ZAMMUC Residence (Usual place of abode) Residence (Usual place of abode Oh Unthous Ida If non-resident, give place and State. It non-resident, give place and State (Years) Birthplace April 9 (City and State or County) (City and State or County) Occupation / Jakmer Occupation Jouren CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE \*/ I hereby certify that I attended the birth of this child, who was | Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Registrar.

PERILLIAN WITE The right and the right and the same and the Priod Registration District has e'catalutt' tuotal To any of the state of the stat indau il tura -island Cotago Carl of there's to serve of Tigothers was at a Ci or production was and to prevent subtlining Source orting Bor alter and now then a Simbor of child of this souther, including a esent bieth .... . (a) u ummin Been wire but now dead Meddene Stood and a short see the A self-branch and the self-branch bearing to the to men recleich nive place and le amor orthat give shire and the A 98 60 Sector (Windows to some time with the second anima el frett THE STATE CONTRACTOR O-mination ... notisalin-0. STANDARY OF THE SAME AND STANDARY OF TAXABLE STANDARY Libertity than I are nearly all to the or of the public wind with the Libertition I the line above chart. there there are no allouding payer in the is different then the father, householder. Charles on early and cied the same of the return of all there

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RECEIVED JUN 20 1930 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH State File No..... CERTIFICATE OF DEATH County of Fanney Registration District No. Local Registrar's No. Primary Registration District No. 2 / N -0 (If death occurred in a hospital or institution, give its name instead of street and number.) 2. FULL NAME (a) Residence. No. (If nonresident give city or town and State) (Usual place of abode) How long in U. S., if of foreign birth? Length of residence in city or town where death occurred. yrs. mos. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 16. DATE OF DEATH 5. Single, Married, Widowed, or Divorced (write the word) 8. SEX 4. COLOR OR RACE (Month) (Year) 5a. If married, widowed, or divorced HUSBAND of 17. I HEREBY CERTLEY, That I attended deceased from (or) WIFE of 6. DATE OF BIRTH (month, day and year) 7. AGE If LESS than 1 day, Years Months Days and that death occurred, on the date stated above, at. hrs. or The CAUSE OF DEATH\* was as follows: min. 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry. (duration) business, or establishment in which employed (or employer) CONTRIBUTORY (c) Name of employer (Secondary) 9. BIRTHPLACE (city or town)\_ 18. Where was disease contracted (State or country) if not at place of death? 10. NAME OF FATHER Did an operation precede death? Was there an autopsy? ... 11. BIRTHPLACE OF FATHER What test confirmed dearnosis? (State or Country) (Address) 12. MAIDEN NAME OF MOTH State the DISEASE CAUSING DEATH, or in deaths from VIOLEN CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE OF MOTHER /city (State or Country) 19. Place of Burial Cremation, or Removal Date of Burial Informant 19 (Address) 20. Undertaker Address

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| NG PERMANENT RECORD be stated EXACTLY, PHYSICIANS should ied. Exact statement of OCCUPATION is | rorm v. s. F. E. M. 1.10. JUN 20 1830 CERTIFICATE Of PLACE OF DEATH  County of Somewille Registration District No.  City of Soldie Fells, The Primary Registration District No.  (No.  usual residence, give facts called for under special information.  2. FULL NAME Beby | et No.2 / y - D State File No. 70922                                                                                                                                          |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ent recon<br>Exactly,<br>it statement                                                          | PERSONAL AND STATISTICAL PARTICULARS  8. SEX   4. COLOR OR BACE   5. SINGLE, MARRIED, WID- OWED OR DIVORCED  (Write the word)                                                                                                                                               | 16, DATE OF DEATH  May 17 19.30                                                                                                                                               |
| G<br>PERMANE<br>be stated<br>ed. Exac                                                          | 6. DATE OF BIRTH  May 17 1930                                                                                                                                                                                                                                               | (Month) (Day) (Year)  17. I HEREBY CERTIFY, That I attended deceased from  19 to                                                                                              |
| BENDE<br>IS A<br>should<br>classif                                                             | 7. AGE    Month  (Day) (Year)   IF LESS than 1   day how many   hrs. or   min.?                                                                                                                                                                                             | that I last saw h alive on                                                                                                                                                    |
| ERVED<br>FINK—<br>applied.                                                                     | 8. OCCUPATION  (a) Trade, profession or particular kind of work                                                                                                                                                                                                             | frenches buth                                                                                                                                                                 |
| S LY                                                                                           | dustry, business or establishment in which employed (or employer)                                                                                                                                                                                                           | Contributory (Secondary) (Duration) (Duration) (Secondary) (Duration) (Duration) (Secondary) (Secondary) (Duration) (Secondary) (Secondary)                                   |
| MA<br>(, WITH<br>should be<br>terms, so<br>n back of                                           | 10. NAME OF Father Frank Cooff 11. BIRTHPLACE                                                                                                                                                                                                                               | (Signed)                                                                                                                                                                      |
| TE PLAINLY, information sharff in plain te instructions on                                     | OF FATHER (State or Country) Basalt Stake  12. MAIDEN NAME OF MOTHER (winta Inuth)                                                                                                                                                                                          | Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.  18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) |
| See See                                                                                        | 18. BIRTHPLACE OF MOTHER OF MOTHER (State or Country) Rox bury Slake  14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE                                                                                                                                                     | At place In the of deathyrsmosdays. Stateyrsmosds.  Where was disease contracted if not at place of death?                                                                    |
| $ \mathcal{E} / \mathcal{U}_{\mathcal{L}} $ M. B.—Every item at CAUSE OF I                     | (Informant)  (Address)  (Address)                                                                                                                                                                                                                                           | Former or usual residence  19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL                                                                                                      |
| N. B. state C. very im                                                                         | Filed Aug 1 # 1930 Secretary Local Registrar                                                                                                                                                                                                                                | 20. UNDERTAKER ADDRESS                                                                                                                                                        |

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DIVISION OF VITAL STATISTICS

DEPARTMENT OF COMMERCE BUREAU OF VITAL STATISTICS C.K. MACEY SPECIAL AGENT

Boise, Idaho

JUL 24 1930

Mrs. F. Croft Idaho Falls BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

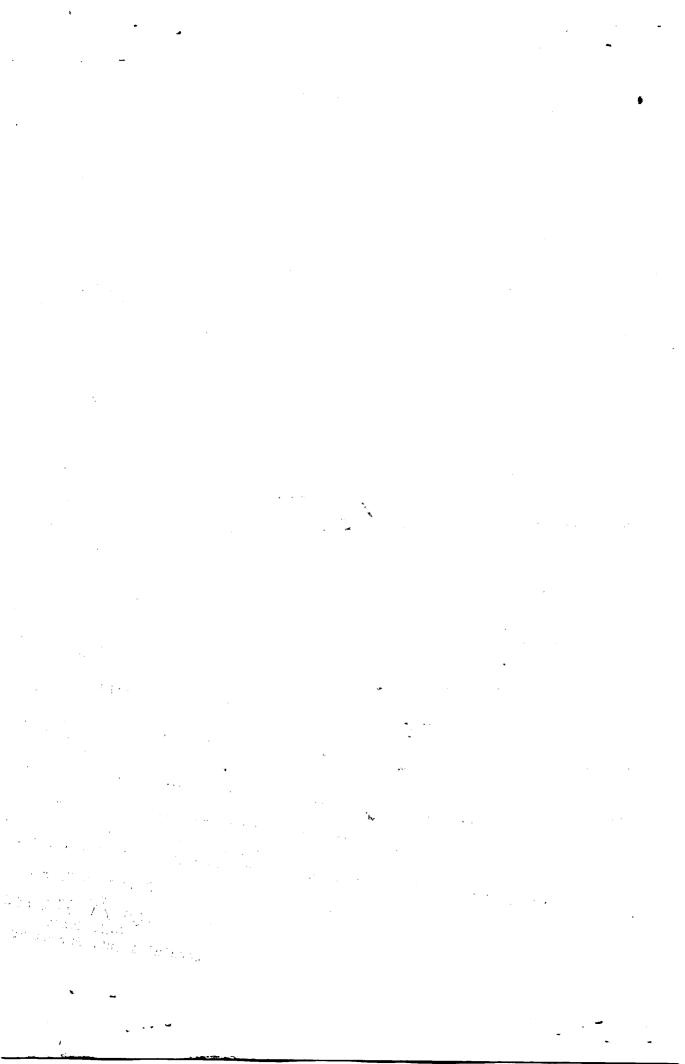
| FULL NAME OF CHILD                                                                                                                                   | nmet             | Smith                        | Croft.                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------|--------------------------------------------|
| PLACE OF<br>BIRTH Idaho Falls                                                                                                                        | DATE OF<br>BIRTH | May 17, 1930                 | SEX OF Male                                |
| <ol> <li>Number of children bern t</li> <li>Number born alive and now</li> <li>Born alive but now dead</li> <li>Number of children stillb</li> </ol> | living           | including present            | birth_5                                    |
| (Pl                                                                                                                                                  | ease write pl    | ainly)                       |                                            |
| Information with reference FATHER  Stancio emmel (Full name)  (Residence)  Age at last birthday  (Birthplace)                                        |                  | Age at last birthday Reshure | Silliams  on name)  Clo Solat  ionco)  37. |
| O.S. L. Brake (Occupation)                                                                                                                           | man              | (BIP                         | iplace)                                    |

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

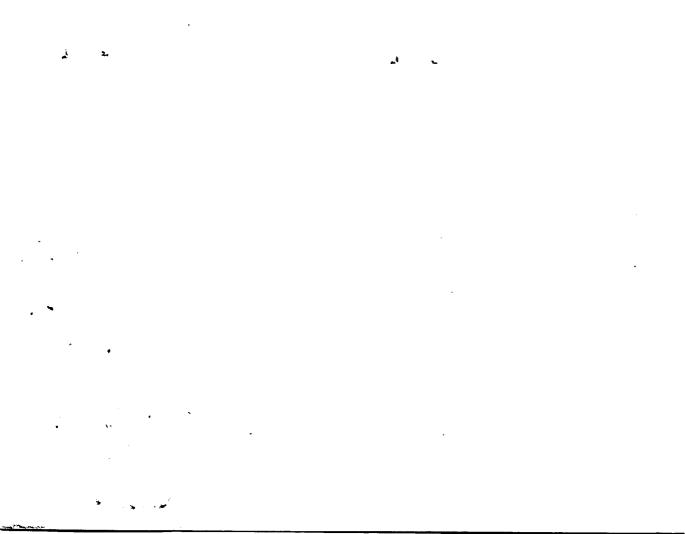
Sincerely Yours,

C.K. Macey

Special Agent, Bureau of the Census.



RECORD be made for EEIVED IIII 5 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County BUREAU OF VITAL STATISTICS City of CERTIFICATE OF BIRTH S A PERMANENT INTERPRESENT INTE Registration District No..... (If born in hospital or institution Local Registrar's No. 30 Prim. Registration District No. give name.) FULL NAME OF CHIL (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Date of Sex of Triplet Legitiin order birth Child of birth (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum?.... Number of child of this mother, including present birth. (a) Born slive and now living Born alive but now dead Stillborr MOTHER each. Residence (Usual place of abode) Residence (Usual place of abode) ... If nonresident, give place and State If nonresident give place and State Age at last Birthday Age at last Birthday Q Birthplace Birthplace City and State or Country) (City and State or Country) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE PLAINLY I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Registrar.



| VT RECORD  tted EXACTLY, PHYSICIANS  Exact statement of OCCUPA- | PLACE OF DEATH  County of City | DO NOT WRITE IN THIS SPACE ATISTICS DEATH  State File No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ANER<br>e sta<br>fied.                                          | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| NG PERMANENT hould be state y classified. F                     | 4. COLOH OR RACE 5. Single, Married, Widowed, or Divorced (write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 16. DATE OF DEATH 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Na Sa                                                           | 5a. H-married, wildowed, or divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| BINDING IS A PE AGE shou properly c                             | HUSBAND of (Or) WIRE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 17 I HEREBY CERTIFY, That I attended deceased doors                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| AG I                                                            | 6. DATE OF BIRTH (month, day and year) Great 4-1930                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | that I last saw han alive on 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                 | 7. AGE Years Months Pays If LESS than 1 day,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | and that death occurred, on the date stated above, at 2 A m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| SD I                                                            | r c c hrs. or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | The CAUSE OF DEATH* was as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>是李石中国</b>                                                    | 8. OCCUPATION OF DECEASED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| RESERV<br>DING IN<br>efully Si<br>so that i                     | (a) Trade, profession, or particular kind of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Sold to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| RE DIN of t                                                     | (h) General nature of industry.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Historia.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| ES, ES                                                          | business, or establishment in which employed (or employer)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (duration) yrs, mos. ds,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| MARGIN<br>H UNFA<br>ild be ca<br>in terms,<br>n on bacl         | (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CONTRIBUTORY<br>(Secondary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| MA ITH ould ain t                                               | 9. BIRTHPLACE (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (duration) yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| VLY, WITI<br>tion shoul<br>H in plain<br>instruction            | (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 18. Where was disease contracted if not at place of death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| on in stru                                                      | 10. NAME OF FATHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Did an operation precede death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                 | 11. BIRTHPLACE OF FATHER (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Was there an autopsy?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| PLAI<br>nform<br>DEA'<br>See                                    | (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What test confirmed diagnosis?  (Signed) , M. D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 트                                                               | 11. BIRTHPLACE OF PARTIER (CITY) (State or Country)  12. MAIDEN NAME OF MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6-26, 19.30 (Address) Lamba                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| WRITE<br>m of i<br>fSE OF                                       | - July                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| WRITE<br>item of i<br>AUSE OF                                   | 18: BIRTHPLACE OF MOTHER (city or town) (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF-INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                 | 14. 14.11: 0. 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 19. Place of Burial, Cremation, or Removal   Date of Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| -Every<br>state (<br>s very                                     | Informant J. J. L.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | WII 1 1 1 1 1 2 193                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| E. E.                                                           | (Address) nonyes the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 80. Undertakent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| N. B.<br>Tion                                                   | 15. Filed Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | noula LI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Z SE                                                            | Agristrar / II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | The state of the s |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs. meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.: Bronchopneumonia (secondary), 10 ds. Never report mere enopheumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Chook" "Uranmi," "Woolmage," etc., whom a definite "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childhith or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning:

spinal fever (the only definite synonym is "Epidemic

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

struck by railway train-accident; Revolver wound of

head-homicide; Poisoned by carbolic acid-probably sui-

cide. The nature of the injury, as fractured skull, and con-

sequences (e. g. sepsis, tetanus) may be stated under the

head of "Contributory."

Do not accept a certificate of death signed only by a midwife.

386 101 027 253 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of 12 20001 BUREAU OF VITAL STATISTICS City of ..... CERTIFICATE OF BIRTH Registration District No.../8....State File No. stated (If born in hospital or institution Prim. Registration District No.....Local Registrar's No..... give name.) FULL NAME OF CHILD CL (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Sex of Legiti-Date of in order Child birth 44 mate? (To be rusw red only in event of plural births) (Day) What prophylactic was used to prevent Ophthalmia Neonatorem? Number of child of this mother, including present birth...... (a) Born alive and now living. Born alive but now dead.....Stillborn FULL MAIDEN NAME (X Residence (Usual place of abode) Residence (Usual place of abode). It non-resident, give place and State If non-resident, give place and Store. Birthplace .... City and State or County) (City and State or County) Occupation Farmer CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was L. Stillborn on the date above stated. \*Where there was no attending physician? or midwife, then the father, householder, (Physician or midwist) etc., should make this return. A stillborn \ child is one that neither breathes nor Address shows other evidence of life after birth.

APPRILA ... The state of the s Trips Trophed and Trips of the Company of the Compa The second secon THE STREET STREET, STR What mediately was west to prevent Oppilicaling Visconstored Some silve and the living the state of the approx, the motion because the name of Marie aller makers of confi The state of the s the second secon House the second that the the the second to the second the second to the (group) to son but the And the party of the state of t THE PARTY OF SALES OF THE SALES Personal Property benefity courter that Cotten led birth or this disto, who was stillness the state whate stated.

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|             |                                                                   | STATE OF ID                             | AHO                         |                                                               | <u></u>              |          |
|-------------|-------------------------------------------------------------------|-----------------------------------------|-----------------------------|---------------------------------------------------------------|----------------------|----------|
| RE          | JUN 2 3 1930                                                      | DEPARTMENT OF PUB                       |                             | DO NOT WRIT                                                   | E IN THIS SPA        | CE       |
|             | PLACE OF DEATH                                                    | BUREAU OF VITAL                         | STATISTICS                  | ļ                                                             | MANCC                |          |
|             |                                                                   | CERTIFICATE O                           | P DEATH                     | State File No                                                 | 71066                |          |
| County      | of Jerome                                                         | Registration District No                |                             |                                                               |                      | _        |
| Cit4        | 2                                                                 | Registration District No                |                             | Local Regist                                                  | rar's No             |          |
| City of     | idrom2                                                            | Primary Registration Distri             | ct No                       | 2,000,100                                                     |                      |          |
|             |                                                                   | (No                                     |                             | )                                                             |                      |          |
|             | (If death occurre                                                 | (Nod in a hospital or institution, give | ts name instead of street a | and number.)                                                  | . 10                 |          |
|             | 0                                                                 | 2. Tomasa                               | -n                          |                                                               | $\sim 0^{\circ}$     |          |
| 2. FU       | ULL NAMEO Jewy                                                    | · JATICE SU                             |                             |                                                               |                      |          |
| (a          | ) Residence. No                                                   |                                         | St.                         | /78                                                           |                      |          |
| Length      | (Usual place of abode)<br>n of residence in city or town where de | ath occurred. vrs. mos.                 | ds. How long in U.S.,       | (If nonresident give cif of foreign birth?                    |                      | ds.      |
| Dengui      |                                                                   |                                         |                             |                                                               |                      | =        |
| •           | PERSONAL AND STATISTIC                                            | AL PARTICULARS                          | _ MED                       | ICAL CERTIFICATE O                                            | F DEATH              |          |
| 8. SE       | 4. COLOR OR RACE                                                  | 5. Single, Married, Widowed,            | 16. DATE OF DE              | ATH / \                                                       | $\mathcal{T}$        | e        |
| m           | who motive                                                        | or Divorced (write the word)            |                             | april 1                                                       | 121 1                | ٦9       |
| 7.00        | 7 00 10-0                                                         | 1-X-71-4                                | -                           | (Month)                                                       | (Day) (Yea           | ır)      |
| 5a. If      | married, widowed, or divorced HUSBAND of                          | 9                                       |                             | RTIFY, That I attended                                        |                      |          |
|             | (or) WIFE of                                                      |                                         | aful 1                      | al, 1930, to af                                               | u St 195             | 3        |
| 0 DA        | ATE OF BIRTH (month, day and year)                                | Pm 1 162                                | that Vast saw h             | 11                                                            | . 19                 |          |
| 7. AG       |                                                                   | Days If LESS than 1 day                 | 9                           |                                                               |                      |          |
| 7. AG       | TEATS MOREIS                                                      | hrs. o                                  | and that death occu         | rred, on the date stated al                                   | oove, at             |          |
|             |                                                                   | min.                                    | The CAUSE OF D              | EATH* was as follows:                                         | +                    |          |
| 8. OC       | CCUPATION OF DECEASED                                             |                                         | - suce                      | som suffa                                                     | $M_{Q-1}$ 1+         |          |
| (a          | ) Trade, profession, or                                           |                                         | ( lury )                    | sion Cord                                                     | Ortra-Mi             | u        |
| pa          | ) Trade, profession, or<br>rticular kind of work                  |                                         |                             | · · · · · · · · · · · · · · · · · · ·                         |                      | <b>-</b> |
| (p          | ) General nature of industry,                                     |                                         |                             | (duration)                                                    | yrsmos               | ******   |
| wh          | siness, or establishment in hich employed (or employer)           |                                         |                             | •                                                             |                      |          |
| (c)         | ) Name of employer                                                |                                         | CONTRIBUTORY<br>(Secondary) |                                                               |                      |          |
|             |                                                                   |                                         |                             | (duration)                                                    | yrsmos               |          |
| 9. BT       | RTHPLACE (city or town)                                           | 1_1                                     | 18. Where was dis           |                                                               |                      |          |
| (S          | State or country)                                                 | conv                                    | if not at place             | of death?                                                     |                      |          |
| 10.         | . NAME OF FATHER                                                  | $\sigma$ 7                              | Did an operation pr         | ecede death? D                                                | ate of               |          |
|             | (x)ew                                                             | en Themeson                             | Was there an auto           | •                                                             |                      |          |
| 02          | DIDMITTI ACE OF PARTIES (-14                                      | . + (m)                                 | What test confirmed         |                                                               | A                    |          |
| 불 11.       | . BIRTHPLACE OF FATHER (city of (State or Country)                | T 1)                                    | (Signed)                    | CB Zell                                                       | en .                 | М.       |
| 11. PARENTS | $\mathcal{C}$                                                     | Vansus                                  | - 4/22                      | X                                                             | oure 2de             |          |
| A 12.       | . MAIDEN NAME OF MOTHER                                           | 1/0/                                    | 7=                          | (Address)                                                     |                      | -        |
|             | Xe                                                                | na very                                 | +State the DIGE             | SE CAUSING DEATH A                                            | r in deaths from VIO | LE       |
| 13.         | . BIRTHPLACE OF MOTHER sity                                       | or, town)                               | CAUSES, state (1            | SE CAUSING DEATH, o<br>MEANS AND NATU<br>TAL, SUICIDAL, or HO | RE OF INJURY, and    | ď        |
|             | (State or Country)                                                | Tunsis.                                 | wnether ACCIDEN             | IAL, SUICIDAL, OF HO                                          |                      |          |
| 14.         | A) mare 9                                                         | Temason                                 | 19. Place of Buria          | Cremation, or Removal                                         | Date of Burial       |          |
| Į.          | nformant                                                          |                                         | 0                           | e Idelu                                                       | apr 2                | 18       |
| ( A         | Address)                                                          | - 1                                     | 20. Undertaker              | <u> </u>                                                      | Address              | _        |
| 15.         | 11 / 1 720 /                                                      | The & Faller                            | Ly. Undertaker              | _                                                             | TAULUT CHO           |          |
| ı Fi        | iled 9 19 22                                                      | Registrar                               | ~~~~                        | _                                                             | 1                    |          |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

|                                                   | · · · · · · · · · · · · · · · · · · ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | $\sim$   |
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| 6                                                 | PLACE OF THE VED JUL 1 2 1920                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STATE OF IDAHO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | _'       |
| ğ                                                 | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | EPARTMENT OF PUBLIC WELFARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 7        |
| ORD<br>be mad                                     | County of Carth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |
| RECORD<br>ust be m                                | M. ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | BUREAU OF VITAL STATISTICS 🛫 💢                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ١        |
| <b>—</b>                                          | City of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | CERTIFICATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |          |
| <b>開始</b>                                         | No. KW . St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 182                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 190      |
| 平 章                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | # 0 C    |
|                                                   | 693-123D29-216 Registration Dis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | trict NoState File No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |          |
| ANEN<br>FURN<br>stated                            | , ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | n District No. 1011 Local Registrar's No. 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 7        |
|                                                   | give name.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>,</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |          |
| <b>SE a</b>                                       | FULL NAME OF CHILD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | m m                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |          |
| PERMANENT RE<br>TE RETURN must<br>I birth stated. | (If stillborn, s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ubstitute the word "Stillbirth" for name of child)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |          |
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|                                                   | Sex of h Twin   Number   in order                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Legiti- Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |
| 429                                               | or other?   of hirth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | mate? // DIFTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1999     |
| IS A PHARATE                                      | (To be answered only in event of plural births                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ) (Month) (Day) (Y                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ear)     |
| S IS A PERM<br>CPARATE RET<br>order of birth      | What prophylactic was used to prevent Ophthalmia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Neonatorum?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |
| SEP I                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |
| THIS & SE                                         | Number of child of this mother, including present birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |          |
|                                                   | Born alive but now dead.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Stillhorn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |          |
| INK—birth                                         | Born alive but now dead                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |
| INK                                               | FATHER /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | FULL MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ,        |
|                                                   | FULL WITTER DE LA SON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | MAIDEN Pearl Dorothy Dawye                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | N.       |
|                                                   | NAME Upon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2. ( )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |          |
| Ž 🕏 💆                                             | Residence (Usual place of abode) Macro Jako                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | سرم      |
| UNFADING<br>one child at                          | The state of the s | # 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |          |
| <b>₹</b> ∂∄                                       | It non-resident, give place and State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | If non-recident, give place and State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |          |
|                                                   | Color or race Mulf Age at last Birthday                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Color or race Age at last Birthday.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 20       |
| the on                                            | Wears)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | - I dahar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (Years)  |
|                                                   | Birthplace Table                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Birthplace (City and State or County)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ·        |
| TTH<br>than                                       | (City and State or County)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Occupation American                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |          |
| WITH<br>e than                                    | Occupation 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |
| LY W<br>more                                      | CERTIFICATE OF ATTENDI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | NG PHYSICIAN OR MIDWIFE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |          |
| LY V<br>more                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Born-alive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (D)      |
|                                                   | I hereby certify that I attended the birth of this                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | child, who was Stillborn at 12:15                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | U. M     |
| ALINI<br>e of<br>for                              | on the date above stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | cititu, who was country in the same succession in the same successio |          |
| . 4 9 2                                           | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | War stand                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |          |
| PLAINLY<br>case of me<br>for each                 | (;                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Signature)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ******** |
| •                                                 | (*Where there was no attending physician)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |          |
| RITE                                              | or midwife, then the father, householder,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (Physician or midwife)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |          |
| · 🗒 (                                             | or midwife, then the father, householder,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |
| WRITE<br>B.—In                                    | etc., should make this return. A stillborn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | dress Procreo Hashal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1        |
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| z                                                 | shows other evidence of life after birth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | leatile of 130 Theory will                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ray      |
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|                                                   | li e e e e e e e e e e e e e e e e e e e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | / -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |          |

THE RESERVE TO STATE OF THE PARTY. Managing Olstriet and Land Tille De Land the Matetration Boltict Vo. Co. A. Lord Materials Mo. J. GOTTO THE TAX THE The second secon Mo of #1 The manufacture in come of placed history Big Hesternate and the contract Commission Manufacture? Annahur, of child of the motion inches present hard here. And there are not been alles and the second изовить. Tions allywhell how stead Sections of Sand place & storie the same of the party of the same to be been been statistics operated policy due color or race of the district of the state of Hirtigula ne (CIO and Said of Cross) dougabaor) THE THE REAL OF ATTEMPTS PRESENTED IN ACCOUNTY OF THE PERSON OF THE PERS the fact that the birth of this child, who not Stillbord the AND THE PROPERTY AND THE .... (Trutenais) Where there was no attending unsultant The state of the s a mitwife chem the failten in eic. should make inte rature. Astrator - 52976BA cluid is gree that actiller i market new the wife out to available pain evode.

| TYSI-<br>state-                                                      | Form V. S. No. 5 20M.1-16-12  1. PLACE OF DEATH.                                                      | VED JUL 1 2 1920<br>CERTIFICATE               | /_ /                                                                           | State of Idaho BOARD OF HEALTH Bureau of Vital Statistics                                        |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
|                                                                      | PLACE OF BEATH.                                                                                       | Registration District No                      |                                                                                |                                                                                                  |
| Bet P                                                                | County of                                                                                             | Primary Registration Distric                  |                                                                                | File No.                                                                                         |
| Þi                                                                   | City of                                                                                               | (No,                                          | st.)                                                                           | Registered No                                                                                    |
| - H                                                                  | If death occurs away from usual residence, give facts called for under special information. 2. FULL N | IAME DAMINUS                                  | en                                                                             | If death occured in a hospital, institution or camp, give its NAME instead of street and number. |
| RECORD.<br>I EXACTLY<br>classified.                                  | PERSONAL AND STATIST                                                                                  |                                               | MEDICAL CERTIF                                                                 | CATE OF DEATH.                                                                                   |
| E 70 -                                                               | 3. SEX 4. COLOR OR BACE                                                                               | 5. SINGLE, MARRIED, WID-<br>OWED OR DIVORCED. | 16. DATE OF DEATH                                                              | 2010                                                                                             |
| [ANEN7]<br>be state<br>properly<br>ficate.                           |                                                                                                       | (Write the word.)                             |                                                                                |                                                                                                  |
| UG<br>EBMANE<br>uld be st<br>be proper                               | 6. DATE OF BIRTH                                                                                      |                                               | (Month)                                                                        | (Day) (Year)                                                                                     |
| 26                                                                   | 6. DATE OF BIRTH                                                                                      |                                               |                                                                                | That I attended deceased from                                                                    |
|                                                                      |                                                                                                       | 1                                             | June 23 19130                                                                  | o June 23 191 J.                                                                                 |
|                                                                      | (Month)                                                                                               | (Day) (Year)                                  | that I last saw halive on                                                      | 191                                                                                              |
| BIN<br>IS L<br>ICE<br>It n<br>back                                   | 7. AGE                                                                                                | IF LESS than 1 day                            | and that death occurred on the                                                 | date stated above, at                                                                            |
|                                                                      | yrsmos                                                                                                | how manyhrs. or                               | The CAUSE OF DEATH* was                                                        |                                                                                                  |
| CHIS<br>d. that                                                      | 8. OCCUPATION                                                                                         | 1                                             | 14.011                                                                         |                                                                                                  |
| IRVED FOUR INK—II supplied in terms, so instructions                 | (a) Trade, profession or                                                                              | •                                             | 77                                                                             |                                                                                                  |
| Light KI                                                             | particular kind of work                                                                               |                                               | Juliano                                                                        |                                                                                                  |
| <b>-</b> 0 + 2                                                       | (b) General nature of industry<br>business, or dstablishment in                                       |                                               |                                                                                | _                                                                                                |
| HER<br>that                                                          | which amployed (or employer)                                                                          |                                               | (Duration) yrs. mos. ds.                                                       |                                                                                                  |
| IN RESER<br>UNFADING<br>be carefully<br>H in plain t<br>ant. See ins | 9. BIRTHPLACE (State or Country)                                                                      | da.                                           | Contributory No / C<br>(Secondary)                                             | man)                                                                                             |
| ~ E ° +;                                                             | 10. NAME OF FATHER WILLOW                                                                             | Wilson                                        | (Signed)                                                                       | yrs. mos. ds.                                                                                    |
| MARGIN<br>WITH UJ<br>should be<br>F DEATH<br>importan                | 11. BIRTHPLACE<br>OF FATHER                                                                           |                                               |                                                                                | moscipi Idaho                                                                                    |
|                                                                      | (State or Country)                                                                                    |                                               | *State the DISEASE CAUSING DEATH; or<br>MEANS OF INJURY; and (2) whether ACCII | in deaths from Violent Causes, state (1).                                                        |
| PLAINLY, information e CAUSE OF                                      |                                                                                                       | Dorothy Sawye                                 |                                                                                | (For Hospitals, Institutions,                                                                    |
| E # # F                                                              | 13. BIRTHPLACE OF MOTHER (State or Country)                                                           | 1                                             | At place of deathyrsmosdays.                                                   | In the Stateyrsmosdays,                                                                          |
| 12 C + 2 42                                                          | 14. THE ABOVE IS TRUE TO THE                                                                          | BEST OF MY KNOWLEDGE                          | Where was disease contracted if not at place of death?                         |                                                                                                  |
| WRIT<br>y item<br>hould s                                            | (Informant)                                                                                           |                                               | Former or usual residence                                                      |                                                                                                  |
| S sho                                                                | 11                                                                                                    |                                               | 19. PLACE OF BURIAL OR RE                                                      | MOVAL DATE OF BURIAL                                                                             |
| S HE                                                                 | 15.                                                                                                   | 0/80                                          |                                                                                | 191                                                                                              |
| N. B.—Every CIANS sh                                                 | Filed July 9 1000                                                                                     | Dany sike Local Registrar                     | 20. UNDERTAKER                                                                 | ADDRESS                                                                                          |
| _                                                                    | SYMS - YORK CO., PTRS. & BDRS. 19760                                                                  |                                               |                                                                                |                                                                                                  |
|                                                                      | · .                                                                                                   |                                               |                                                                                |                                                                                                  |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager." "Dealer," etc., without more precise specification, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: Farmer (retired, 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia." unqualified, is indefinite); Tuberculosis of lungs, use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy", "Collapse," "Coma," "Convulsions," "Debility, ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Unamic", "Woolsoog," as he is a left in the content of the c "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUER-PERAL, septicemia", "PUERPERAL peritonitis," etc... all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train -accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory."

STATE OF IDAHO PERMANENT RECORD TE RETURN must be made DEPARTMENT OF PUBLIC WELFARE County BUREAU OF VITAL STATISTICS City CERTIFICATE OF BIRTH State File No. Registration District No ..... (If born in hospital or institution Prim. Registration District No. Local Registrar's No... give name.) FULL NAME OF CHILD order of birth (If stillborn, substitute the word "Stillbirth" for name of shild) THIS IS A PER h a SEPARATE 1 th, in order of bin Number Twin Date of Legiti-Sex of Triplet and in order mate? UE hirth Child or other? (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? birth a FULL MAIDEN FULL NAME. 7 UNIFADING one child at number Residence (Usual place of abode Residence (Usual place of abode) If non-resident, give place and State It non-resident, give place and State Color or race Color or race. the Birthplace Birthplace .... than (City and State or County) (City and State or County) Occupation of Atrico Occupation . more CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE PLAINLY Case of mo Barneslive I hereby certify that I attended the birth of this child, who was Atillborn, on the date above stated. 특 \*Where there was no attending physician? or midwife, then the father, householder, (Physician 🍑 etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Registrar.

WRITE

the bearing portant and September 10-Late of Comment Print Resident Charles W. EXAMPLE OF VIEW PARTY. in a company and the country of the men. Contact Lawre to the beautiful and the second The manufacture was ment to previous Opharaciants Noonanow unaffering the second of th The second of the second and the second of the second of the second of the second seco the sure time with street Mandage II was proceeded Transportation Black and the second COMPANY THE PROPERTY. Course of the little of the little of the little of Distantant. Company of the Principle of the Company of the Comp and the second or optimies of BETTER OF AUTOMONOPHINE OF MERCANN OF MARKET the second second of the country was been as a second seco tratale free talk state and The block that the transfer of the state of TO THE PARTY OF TH TOTAL THE THE PARTY OF THE PART the state of the next the same of the same

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| A, PHYSICIANS nent of OCCUPA-                                                                                                                                                                                                                                                                                                        | PLACE OF DEATH  County of City of Celebrate City | C WELFARE DO NOT WRITE IN THIS SPACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MARGIN RESERVED FOR BINDING WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD Every item of information should be carefully supplied. AGE should be stated EXACTLY, Istate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements every important. See instruction on back of certificate. | Primary Registration District                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | St.  St. (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.  MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  17. I HEREBY CERTIFY, That I attended deceased from that I last saw harta alive on the date stated above, at mos.  The CAUSE OF DEATH was as follows:  (duration) yrs. mos. ds.  (contributory (Secondary)  (duration) yrs. mos. ds.  18. Where was disease contracted if not at place of death?  Did an operation precede death? Date of.  Was there an autopsy?  What test confirmed diagnosis?  (Signed) , M. D.  *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT (AUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  19. CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| N. B<br>should<br>TION                                                                                                                                                                                                                                                                                                               | 15. Filed Jan / , 1930 Sus an & Bruce Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | assar Morcus du Levelos da                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

1.00

| 265 222-035 796                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| PLACE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STATE OF IDAHO                                                       |
| PECEIVED JUL 1 4 1930 DE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | EPARTMENT OF PUBLIC WELFARE                                          |
| County of the Pure                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | BUREAU OF VITAL STATISTICS                                           |
| A I A I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | CERTIFICATE OF BIRTH                                                 |
| City of the control o | (/ 109570                                                            |
| NoSt. Registration District                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | No. 96 File No. 182572                                               |
| TVit1 Delice Designmention                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | District No. 1009 Registered No.                                     |
| Hospital Primary Registration                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | District No Registered No                                            |
| FULL NAME OF CHILD Virginia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Iweit                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | cate of no value without full name of child.)                        |
| Sex of M Twin Number Triplet and in order                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Logiti- 4 Date of 4-21- 1030                                         |
| Child or other? (To be answered only in event of plural bit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                      |
| 1 (10 be kniswered only in event of plans) on                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (month) (Day) (1ear)                                                 |
| What bactericidal solution was used in eyes?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                      |
| Number of child of this mother, including present birth Nu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | mber of children of this mother now living, including present birth. |
| FULL NAME ) GROLD FATTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | FULL MOTHER MAIDEN Jose Brown                                        |
| RESIDENCE TO A LA SOL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | RESIDENCE .                                                          |
| Teward pour ver, you.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | COLOR AGE AT LAST 20                                                 |
| COLOR AGE AT LAST 30 BIRTHDAY 30                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | BIRTHDAY                                                             |
| BIRTHPLACE T. (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | BIRTHPLACE A D D (Years)                                             |
| W colinglos                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Oplatona.                                                            |
| OCCUPATION .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | OCCUPATION T                                                         |
| Jahnen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Honoewife.                                                           |
| CERTIFICATE OF ATTENDI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | NG PHYSICIAN OR MIDWIFE                                              |
| I hereby certify that I attended the birth of this child, who                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | was still to at the M.                                               |
| on the date above stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (Benelive or stillborn)                                              |
| *When there was no attending physician or<br>midwife, then the father, householder, etc., (Signatu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | THI Jourse m. T)                                                     |
| midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evi-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 16)                                                                  |
| dence of life after birth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                      |
| Give names added from a supplemental report.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Lewiston (Physician or midwife)                                      |
| Address, 192                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 7 11 24 Spar Julle                                                   |
| Registrar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1920 Registrar.                                                      |

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| <b>70 I</b> . I                                              | 1                 | , , , , , , , , , , , , , , , , , , , ,                    | STATE OF IDAE                        | 10                                                                                                 | Rom                                     | A. C.                                                     |
|--------------------------------------------------------------|-------------------|------------------------------------------------------------|--------------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------------------------|
| PAR                                                          |                   | RECEIVED JUN 1 7 1930                                      | DEPARTMENT OF PUBLIC                 | C WELFARE                                                                                          |                                         | IN THIS SPACE                                             |
| PHYSICIAN<br>of OCCUPA                                       | -                 | -PLACE OF DEATH                                            | BUREAU OF VITAL ST                   | ATISTICS                                                                                           | a                                       | 19 1 5 1                                                  |
| XS<br>OC                                                     | Co                | unty of Nez Perce.                                         | CERTIFICATE OF                       | 987 Z PL 1/1                                                                                       | State File No                           |                                                           |
| PH<br>of                                                     | į                 | ty of Lewiston.                                            | Registration District No             | 1 /1 /1/27                                                                                         | Local Registra                          | ır's No                                                   |
| ,Y,                                                          | O.                |                                                            | Primary Registration District        | •                                                                                                  | ,                                       |                                                           |
| EECORD<br>EXACTLY,<br>act statemen                           | Ì                 | (If death occurred                                         | (No                                  | name instead of street and                                                                         | number.)                                |                                                           |
| RECORD<br>EXACT                                              | 9                 | FULL NAME Virginia Sw                                      |                                      |                                                                                                    | De la Company                           |                                                           |
| # _ ×                                                        | ۷.                |                                                            |                                      |                                                                                                    | Orchards.                               | ······                                                    |
| ated<br>E                                                    | (a) Residence. No |                                                            |                                      | (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds. |                                         |                                                           |
| DING<br>A PERMANENT<br>should be state<br>erly classified. F | F                 | PERSONAL AND STATISTICA                                    |                                      | MEDIC                                                                                              | AL CERTIFICATE OF                       | DEATH                                                     |
| MA.<br>be                                                    | 8.                | SEX 4. COLOR OR RACE                                       | 5. Single, Married, Widowed,         | 16. DATE OF DEAT                                                                                   | H                                       |                                                           |
| G ER                                                         | "                 | Female. White.                                             | or Divorced (write the word) Single. |                                                                                                    | oril 22nd, 193<br>(Month) (I            |                                                           |
| BINDING<br>IS A PER<br>AGE shoul<br>properly cl              | 58                | a. If married, widowed, or divorced<br>HUSBAND of          |                                      |                                                                                                    |                                         | Oay) (Year)                                               |
| BINDIN<br>IS A F<br>AGE sh<br>properly                       | )<br>             | HUSBAND of<br>(or) WIFE of                                 |                                      |                                                                                                    | FIFY, That I attended de                |                                                           |
| S J AC                                                       | 6                 | DATE OF BIRTH (month, day and year)                        | April 22nd, 1930.                    | that I last saw h                                                                                  | •                                       | , 19                                                      |
| FOR 1<br>THIS<br>ed. A<br>ty be p                            | l i——             |                                                            | Days If LESS than 1 day,             | and that death occurre                                                                             | d, on the date stated abo               | ve, atm.                                                  |
| VED FO INK—TH supplied. it may bificate.                     |                   |                                                            | min.                                 | The CAUSE OF DEA                                                                                   | TH* was as follows:                     |                                                           |
| SERVED FOR INK—THE SUPPLIED IN SUPPLIED.                     | 8.                | OCCUPATION OF DECEASED                                     |                                      | 19:01                                                                                              | Lann                                    |                                                           |
| RESER<br>DING I<br>efully a<br>so that<br>of cert            | l                 | (a) Trade, profession, or NO particular kind of work.      | ni.                                  | Aug >                                                                                              |                                         | times at a minimum.                                       |
| I UNFADING I be carefully terms, so that on back of ce       |                   | (b) General nature of industry,                            |                                      |                                                                                                    | (duration)                              | .yrs                                                      |
| IFA<br>Can                                                   |                   | business, or establishment in which employed (or employer) |                                      | CONTRIBUTORY                                                                                       |                                         |                                                           |
| MARGIN<br>TH UNE,<br>ald be can<br>terms,<br>n on bac        |                   | (c) Name of employer                                       |                                      | (Secondary)                                                                                        |                                         | _                                                         |
| WITH<br>WITH<br>should<br>plain<br>ction o                   | 9                 |                                                            | viston, I                            | 18. Where was diseas                                                                               |                                         | yrsds.                                                    |
|                                                              |                   | (State or country) Ide                                     | ho.                                  | if not at place of                                                                                 | death?                                  |                                                           |
| NLY,<br>ttion (<br>l'H in<br>instru                          |                   | 10. NAME OF FATHER H. R. S                                 | Sweet.                               | Did an operation prece                                                                             | 20.13                                   | e of                                                      |
| PLAINLY,<br>nformation<br>DEATH in<br>See instr              | 202               | 11. BIRTHPLACE OF FATHER (city or                          |                                      | Was there an autopsy What test confirmed d                                                         |                                         |                                                           |
| Se Se Se                                                     | FNS               | (State or Country)                                         | Washington.                          | (Signed)                                                                                           | 7/1/Low                                 | , M. D.                                                   |
|                                                              | PARENTS           | 19 MAIDEM NAME OF MOTHER                                   | WOOMING COM.                         | <b>4/23/3</b> 0 , 19                                                                               | (Address)Lewis                          | ton, Idaho.                                               |
| RITE<br>of i                                                 | "                 | 12. MAIDEN NAME OF MOTHER 18318                            | Mae Brown.                           | •State the DISEASE                                                                                 | CAUSING DEATH, or                       | in deaths from VIOLENT                                    |
| WRITE item of i                                              |                   | 13. BIRTHPLACE OF MOTHER (city of (State or Country)       | town) Oklahoma.                      | CAUSES, state (1) whether ACCIDENTA                                                                | MEANS AND NATURI<br>L, SUICIDAL, or HOM | in deaths from VIOLENT<br>C OF INJURY, and (2)<br>ICIDAL. |
| , <sub>&gt;0</sub> >                                         | 1                 | 4. Informant OJ R. A                                       | west.                                | 19. Place of Burial, C                                                                             | Cremation, or Removal                   | Date of Burial                                            |
| 572<br>Ever<br>state<br>is ver                               |                   | (Address) Lewiston,                                        | Idaho.                               | Lewiston, Ida                                                                                      | ho.                                     | 4/23/30. 19                                               |
| N E N                                                        | 1                 | 5. Filed Jun / , 1930 S                                    | ruan E Bruce                         | 20. Undertaker                                                                                     | lomnonir                                | Address<br>Lewiston, Idaho                                |
| \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\                        |                   | Filed State 19                                             | Registrar                            | Brower-Wann C                                                                                      | ombarra.                                | Tem 19 nott' Temtro                                       |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

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"Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

| 445 124 035 261                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| PLACE OF PURTUE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STATE OF IDAHO                                                      |
| 3 001 14 300                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | EPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS              |
| County of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                     |
| City of Lewislay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | CERTIFICATE OF BIRTH                                                |
| Registration District                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | No. 96 File No. 182573                                              |
| NoSt.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | /                                                                   |
| Hospital Primary Registration                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | District No. 100 Registered No.                                     |
| BULL NAME OF OWNER Soling Is                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | mulell                                                              |
| FULL NAME OF CHILD (Certifi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | cate of no value without full name of child.)                       |
| Sex of ZA Twin Triplet and (Number in order                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Legiti- / / Date of 4-24-30                                         |
| Child or other? (To be answered only in event of plural bin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | mate? All birth 192                                                 |
| 100 be answered only in event of planar on                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2007 (James) (Month) (Day) (Tear)                                   |
| What bactericidal solution was used in eyes?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | We way your                                                         |
| Number of child of this mother, including present birth Nu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | mber of children of this mother now living, including present birth |
| FULL NAME FATHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | FULL MOTHER MAIDEN                                                  |
| Job G. Thunsul                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | NAME TONK TOOK .                                                    |
| RESIDENCE Lewiston Ida.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | RESIDENCE Serviston, Ida-                                           |
| COLOR AGE AT LAST 2 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | COLOR AGE AT LAST                                                   |
| BIRTHDAY (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | BIRTHDAY(Years)                                                     |
| BIRTHPLACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | BIRTHPLACE C                                                        |
| and the same of th | accuration.                                                         |
| occupation falisman.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | OCCUPATION Housenste.                                               |
| CERTIFICATE OF ATTENDI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | NG PHYSICIAN OR MIDWIFE*                                            |
| I hereby certify that I attended the birth of this child, who                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | was M                                                               |
| on the date above stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (Recollition)                                                       |
| *When there was no attending physician or<br>midwife, then the father, householder, etc (Signatu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | in that M.D.                                                        |
| should make this return. A stillborn child is one that neither breathes nor shows other evi-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                     |
| (dence of life after birth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (Physician/ar midwife)                                              |
| Give names added from a supplemental report.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Jewiston Sil                                                        |
| Address, 192                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1 (0 9) MAN 1/1/0                                                   |
| Filed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1-10 1920                                                           |
| Registrar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Registrar.                                                          |

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| RECORD EXACTLY, PHYSICIANS cact statement of OCCUPA-                                                                 | STATE OF IDEATH STATE OF IDEATH STATE OF IDEATH STATE OF PUBL BUREAU OF VITAL STATE OF CERTIFICATE OF CERTIFICATE OF Registration District No                                                                                   | DEATH  t No                                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| E - E                                                                                                                | (Usual place of abode)                                                                                                                                                                                                          | St. (If nonresident give city or town and State)                                                                                                                                                                         |
| BINDING IS A PERMANENT AGE should be state properly classified. F                                                    | PERSONAL AND STATISTICAL PARTICULARS  8. SEX 4. COLOR OR RACE 6. Single, Married, Widowed, or Divorced (write the word)  51 If married, widowed, or divorced HUSBAND of                                                         | MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  April 24th, 1930.  (Month) (Day) (Year)  17. I_HEREBY CERTIFY, That I attended deceased from                                                                            |
| FOR<br>THIS<br>led.                                                                                                  | 6. DATE OF BIRTH (month, day and year) April 24th, 1930.  7. AGE Years Months Days If LESS than 1 day, hrs. or min.  8. OCCUPATION OF DECEASED                                                                                  | that I last saw h alive on , 19 and that death occurred, on the date stated above, at m.  The CAUSE OF DEATH* was as follows:                                                                                            |
| MARGIN RESERVED WITH UNFADING INK— should be carefully suppli plain terms, so that it mo ction on back of certificat | (a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer  9. BIRTHPLACE (city or town) Lewiston, (State or country) | (duration) yrs. mos. ds.  CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.  18. Where was disease contracted                                                                                                            |
| PLAINLY, Vinformation s<br>DEATH in See instruc                                                                      | 10. NAME OF FATHER  L. E. Mundell.  11. BIRTHPLACE OF FATHER (city or town) Hugo, (State or Country)  Colorado.  12. MAIDEN NAME OF MOTHER Verna Swartz.                                                                        | if not at place of death?  Did an operation precede death?  Was there an autopsy?  What test confirmed diagnosis?  (Signed)  4/24/30., 19. (Address) Lewiston, Idaho.                                                    |
| WRITE fitem of i                                                                                                     | 18. BIRTHPLACE OF MOTHER (city or town) Boulder, (State or Country) Colorado.                                                                                                                                                   | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  19. Place of Burial. Cremation, or Removal Date of Burial |
| . B.—Every<br>hould state (<br>ION is very                                                                           | 14. Informant (Address) Lewiston, Idaho.  15. Filed Jun / 1930. 87 Man 2 Price Registrar                                                                                                                                        | 19. Place of Burial, Cremation, or Removal  Lewiston, Idaho.  20. Undertaker  Brower-Vann Company  Lewiston, Idaho.  Address Lewiston, Idaho.                                                                            |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH-Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS-Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

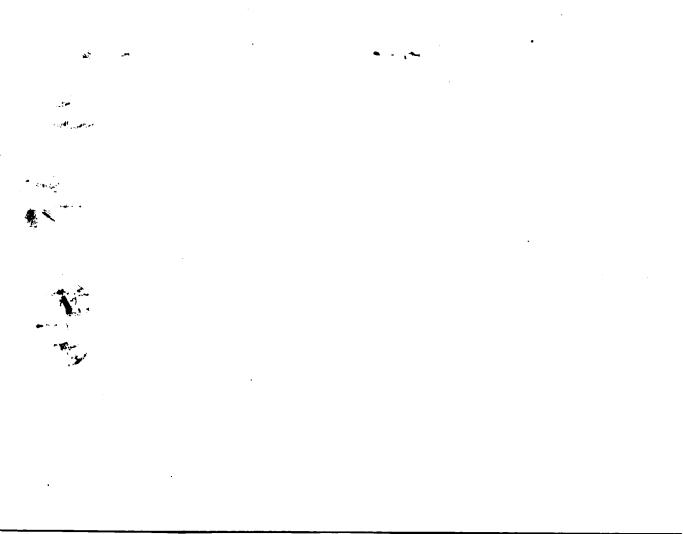
Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

| :      | PLACE REBERGED JUL 8 1930                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STATE OF IDAHO                               |
|--------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| : [    | County of DEPART                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | MENT OF PUBLIC WELFARE                       |
| •      | RIIRI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | EAU OF VITAL STATISTICS                      |
| 1      | City of Ornalis City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ERTIFICATE OF BIRTH                          |
| 3      | No St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 182586                                       |
|        | 386-105-035-314 Registration District                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | NoState File No                              |
|        | (If born in hospital or institution                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                              |
|        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | District NoLocal Registrar's No              |
| 3      | FULL NAME OF CHILD NO NOWS STILL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | So-M                                         |
| stated | (If stillborn, substit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ite the word "Stillbirth" for name of child) |
| 3 1    | Twin Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Legiti- Date of / 97                         |
| pirth. | Child \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | mate?dian birth 1910                         |
| · — ·  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (Month) (Day) (Year)                         |
| ď      | The property of the property o | orum? Wrva Wall                              |
| order  | Number of child of this mother, including present birth (a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Born alive and now living                    |
| 4 1    | II DOTA SIIVE DUL HOW GESG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | born MUL                                     |
| :.E    | FAIRER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ULL \ MOTHER                                 |
| each   | NAME WILL MANNE MANNE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | AIDEN Helen Joann                            |
| 8      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | sidence (Usual place of abode)               |
| 9      | - 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ~                                            |
| 호      | If nonresident, give place and State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | nonresident, give place and State            |
| numbe  | Color or race A Age at last Birthday Co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | lor or race WWW Age at last Birthday         |
|        | Birthplace (Years) Bi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | rthplace FM alamo\ (Years)                   |
| the    | (City and State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (City and State or Country)                  |
|        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | eupation Humanill                            |
| and    | CERTIFICATE OF ATTENDING P                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | HYSICIAN OR MIDWIFE*                         |
| ų      | I hereby certify that I attended the birth of this child,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                              |
| Bac    | on the date above stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 13. 11.00 Think                              |
|        | (Signatu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | re)                                          |
|        | *Where there was no attending physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Omercian                                     |
|        | or midwife, then the father, householder,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (Physician or midwife)                       |
| ·      | etc., should make this return. A stillborn child is one that neither breathes nor Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Sommers Lamo                                 |
|        | shows other evidence of life after birth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 10 C . A B B 7100 F                          |
| .      | Filed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | me y 1950 12.7; VW/5W                        |
| '∦     | <b>/</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Registrar.                                   |



| <b>જ</b> 4                                                                                         | RECEIVED JUL 8 1980 STATE OF IDAI                                                 | но                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PHYSICIAN<br>of OCCUPA                                                                             | DEPARTMENT OF PUBLIC                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <u> </u>                                                                                           | - PLACE OF DEATH BUREAU OF WITAL ST                                               | ATISTICS 71124                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                    | County of Mos React CERTIFICATE OF                                                | DEATH State File No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| ₩*                                                                                                 | Registration District No                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                    | City of Alaka City of Primary Registration District                               | No6.3 Local Registrar's No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Ž                                                                                                  | (No                                                                               | )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| r RECORD<br>ed EXACTLY, Exact statement                                                            | (If death occurred in a hospital or institution, give its                         | name instead of street and number.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| A X X                                                                                              | 2. FULL NAME WONE STILL YOUN MANY                                                 | 1 mrs In wiens                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Kac                                                                                                | (a) Residence. No. Swittman any                                                   | St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| ENT stated                                                                                         | (Herel place of shode)                                                            | (If nonresident give eity or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| - d)                                                                                               |                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| G<br>ERMAN<br>ould be<br>classifii                                                                 | PERSONAL AND STATISTICAL PARTICULARS                                              | MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH \( \)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| RA<br>Id                                                                                           | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word) | L. DATE OF DEATH BULL 4 TA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| ING<br>PERI<br>should<br>rly clar                                                                  | male mus single                                                                   | (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                    | 5a. If married, widowed, or divorced HUSBAND of                                   | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| BINI<br>IS A<br>AGE<br>prope                                                                       | (or) WIFE of                                                                      | Am 2 4 , 19 3D, to fund 4, 1930                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                    | 6. DATE OF BIRTH (month, day and year)                                            | that I last saw have after a along an Right 1930                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| FOR THIS ed. A                                                                                     | 7. AGE Years Months Days If LESS than 1 day,                                      | and that death occurred, on the date stated above, atm.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| I = 6 -                                                                                            | O D hrs. or                                                                       | The CAUSE OF DEATH* was as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| RVE<br>INK<br>sup<br>sup<br>rtific                                                                 | 8. OCCUPATION OF DECEASED                                                         | ajed in www                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>—</b>                                                                                           | (a) Trade, profession, or particular kind of work                                 | Ctrit Barra                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| RGIN RESERVED<br>UNFADING INK—<br>be carefully suppl<br>erms, so that it m<br>n back of certifica! | (b) General nature of industry,                                                   | Sva irrv                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                    | business, or establishment in which employed (or employer)                        | (duration) yrsmosds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| RGII<br>UNF<br>be c                                                                                | (c) Name of employer AAMA                                                         | CONTRIBUTORY (Secondary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>₹</b>                                                                                           | (c) rime or carbon VVP                                                            | (duration) \ yrs, \ mos. \ ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| MANTH<br>WITH<br>Should<br>plain<br>ction                                                          | 9. BIRTHPLACE (city or town)                                                      | 18. Where was disease contracted A. N. KAAMAM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Sh W                                                                                               | (State or country)                                                                | if not at place of death!                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 'X',<br>On 8                                                                                       | 10. NAME OF FATHER DITTUM AND                 | Did an operation precede death? What Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| PLAINLY<br>nformation<br>DEATH See inst                                                            | 11. BIRTHPLACE OF FATHER (city or town)                                           | Was there an autopsy?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| PLAI<br>Iforma<br>DEA7<br>See                                                                      | (State or Country)                                                                | What test confirmed diagnosis?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                    | (State or Country)  12. MAIDEN NAME OF MOTHER  12. MAIDEN NAME OF MOTHER          | (Signed) , M. D. (Address) Chandanada Dala                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                    | 12. MAIDEN NAME OF MOTHER                                                         | Otto Comment of the C |
| →<br>WRITE<br>item of i<br>AUSE OF<br>important.                                                   | 18. BIRTHPLACE OF MOTHER (city or town)                                           | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| → ite                                                                                              | (State or Country) & Ma-lama                                                      | whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| , PO P                                                                                             | 14. Clather H I want to                                                           | 19. Place of Burial, Cremation, or Removal Date of Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| تدنع                                                                                               | Informant (Address)                                                               | Similarede Comitoria June 5 1930                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                                    | (Address)                                                                         | 20. Undertaker Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                    | Filed 5, 1930 6 F. Registrar                                                      | were -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| /_ Z.4E                                                                                            | Registrar                                                                         | YYY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman. (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine. etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs. meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough: Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere chopheumonia (secondary), 10 us. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Chall" "Theorie" "Wolfers" of the property of the construction of th "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis." etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident: Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

| ¥                                     | PLACE OF IDAHO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| B.                                    | County of Lunt tall DEPARTMENT OF PUBLIC WELFARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>E</b> S                            | RUREAU OF VITAL STATISTICS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| S 를                                   | City of Tunn Follows CERTIFICATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| RECORD<br>be made for                 | Noc 2-223 042 119 st. CERTIFICATE OF BIRTH D1 0 7700                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| E E                                   | TEC 4 9 Registration District No. 37 State File No. 366 UN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                       | - And the state of |
| ZZ.                                   | give name.)  Prim. Registration District No2085 Local Registrar's No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| PERMANENT<br>RETURN must<br>h stated. | FULL NAME OF CHILD 5 till 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| ET.                                   | (If stillborn, substitute the word "Stillbirth" for name of child)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>5</b> 2 4                          | Sex of Triplet and in order Legiti- Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| A Bir                                 | Child Torother? (To be answered only in event of plural births) mate? (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| IS<br>A7                              | 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| AR                                    | What prophylactic was used to prevent Ophthalmia Neonatorum?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| SEP.                                  | Number of child of this mother, including present birth (a) Born alive and now living O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 1 -                                   | Born alive but now dead O Stillborn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Ääi.                                  | FATHER MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Et4                                   | NAME COLL COLLUNG BOND NAME TO Server former                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| G 2 2                                 | Residence (Usual place of abode) Full RT Residence (Usual place of abode) Full RT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Na se                                 | 9.2.1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| UNFAD<br>ne child<br>number           | If nonresident, give place and State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| UNF<br>me ch<br>numb                  | Color or race Age at last Birthday Color or race Age at last Birthday                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                       | Birthplace   Kan (Years)   Birthplace   Day 3 days (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 田島                                    | (City and State or Country) (City and State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| E4.                                   | Occupation Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 2 4                                   | CERTIFICATE OF ATTENDING PHISICIAN OF MIDWIFE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 584                                   | I hereby certify that I attended the birth of this child, who was Stillborn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| PLAINLY                               | on the date above stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Y</b> •                            | (Signature) Turk Way                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| PLA                                   | ( *Where there was no attending physician )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                       | or midwife, then the father, householder, (Physician or midwife)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| ≣T I                                  | etc., should make this return. A stillborn Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| WRITE<br>B.—In                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Ż                                     | shows other evidence of life after birth. Filed July 4 11 1930 Clination 1930                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| -                                     | // (/ Megintrax.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

STATE OF IDAHO 1930 DEPARTMENT OF PUBLIC WELFARE County BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH PERMANENT .\.\.\.State File No. Registration District No.... (If born in hospital or institution Prim. Registration District No 2003 Local Registrar's No. \_\_\_\_\_\_\_ give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stiffbirth" for name of shild) Twin Sex of Date of Legiti-Triplet in order Child birth or other1 mate? (To be answered only in event of plural births) (Mohth) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonathrum? Zana Number of child of this mother, including present birth.. Born alive but now dead ..... .Stillborn ATHER FULL MOTHER MAIDEN NAME ..... It non-resident, give place and State If non-resident, give place and State LL....Age at last Birthday.... Birthplace (City and State or County) (City and State or County) Occupation .... Occupation .... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was attillhoun on the date above stated. CASE \*Where there was no attending physician? or midwife, then the father, householder, (Physician or midself etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

OHACI OF TYPE THATTHERE OF PRELIGHTLE !! TO LETTER THE TO BE SPICE. SECURITY TO APPROPRIED CO. The letted District Mo. Prim Registration Missist No. 12 4 1 Conseque Con CHILD WE SHELD THE if stillboen, substitute the ware midwing tor name of stild and the state of t That throughtening to mand to moreous Unittended Meanathrough ariodility... MOTRER PULL Principles Lines play and plant Marie b out tout I was a If non-tendent, give place and State Tabul till Jan 18 and Color of face x ... Ago'nt line Blittedex. Occurrention .... resident TOTAL STREET, NO. ATTENDING PHENCIAL OF SUMMING three certify that I sitreduct the hirthest this child, who was suffering hotels spote state ut ated. de Where there was an atlenting physician Thirdiotal or minactel as delivery, then the father, householder, ete, should no be this white A elithony ton applicant spiriting both and at Altitle distribution for application and a least to be produced to a spiriting and a spiri Addres

| NT RECORD ated EXACTLY, PHYSICIANS Exact statement of OCCUPA- | PLACE OF DEATH  PLACE OF DEATH  County of City of Meridian  City of Meridian  (If death occurred in a hospital or institution, give its                                                         | C WELFARE DO NOT WRITE IN THIS SPACE STATISTICS  DEATH  State File No. 71293  Local Registrar's No. 6                                                         |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ENT Estated                                                   | (a) Residence. No                                                                                                                                                                               | St.  (If nonresident give city or town and State)  How long in U. S., if of foreign birth? yrs. mos. ds.                                                      |
| Fig. A.N.                                                     | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                            | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |
| ING<br>PERMANENT<br>should be state<br>ily classified.        | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)                                                                                                               | 16. DATE OF DEATH  (Month) (Day) (Year)                                                                                                                       |
| BINDING IS A PE AGE shou                                      | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                                                                                                    | (Month) (Day) (Year)  17. I HEREBY CERTIFY, That I attended deceased from 7-7-30, 19, to 7-7 1970                                                             |
| ~~~                                                           | 6. DATE OF BIRTH (month, day and year)                                                                                                                                                          | that I last saw have on 7-7-, 1920                                                                                                                            |
| FOR THIS ed. 1                                                | 7. AGE Years Months Days If LESS than 1 day, hrs. or                                                                                                                                            | and that death occurred, on the date stated above, at                                                                                                         |
| ED FC<br>K—TE<br>pplied.<br>may licate.                       | min.                                                                                                                                                                                            | The CAUSE OF DEATH* was as follows:                                                                                                                           |
| GIN RESERV INFADING IN e carefully su rms, so that it         | 8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer | (duration) yrs. mos. ds.                                                                                                                                      |
| MAR<br>WITH U<br>should b<br>plain te                         | 9. BIRTHPLACE (city or town) Muridians (State or country)                                                                                                                                       | (duration) yrs. mos. ds.  18. Where was disease contracted if not at place of death?                                                                          |
| . EE                                                          | 10. NAME OF FATHER Charles & Symmes                                                                                                                                                             | Did an operation precede death? Date of Was there an autopsy?                                                                                                 |
| E PLAINLY<br>information<br>F DEATH int. See inst             | 11. BIRTHPLACE OF FATHER (city or town) (State or Country)  12. MAIDEN NAME OF MOTHER                                                                                                           | (Signed) , M. D.                                                                                                                                              |
| WRITE<br>item of i<br>AUSE OF<br>important.                   | 12. MAIDEN NAME OF MOTHER HOTA THOSE E<br>18. BIRTHPLACE OF MOTHER (city or town) Arkunan (State or Country)                                                                                    | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| Every state C                                                 | 14. Informant Charles Summer 2<br>(Address) Marchan JA R - 3                                                                                                                                    | 19 Place of Burial, Cremation, or Removal Date of Burial  Mender Curretty July 7 1970                                                                         |
| N. B.—<br>should<br>TION i                                    | 15. Filed 7-8 , 1932. The Registrar                                                                                                                                                             | 20. Undertaker Mendian Mendian                                                                                                                                |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer. Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia." unqualified, is indefinite): Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of ...... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough: Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere coopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Wakness," etc., when a definite disease can be ascertained as the cause. Always qualify a "PULER DEPAL santiamia," "Puler puler as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide: Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

## RECEIVED SEP 6 1980

DIVISION OF VITAL STATISTICS

DEPARTMENT OF COMMERCE BUREAU OF VITAL STATISTICS

-C.K. MACEY SPECIAL AGENT

Boise, Idaho\_

AUG 23 1930

Mrs. C.E. Summers Meridian 182791

BIRTH FEGISTRATION IS A FART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be nade complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

| PLACE OF Meridian                                      | DATEOF          | July 7, 1930          | SEX OF              |
|--------------------------------------------------------|-----------------|-----------------------|---------------------|
| BIRTH MOPILIAN                                         | TAUSE IN        | July 1, 1900          | CHILD_              |
| l. Number of children bor                              | n to this mothe | r, including prese    | nt birth 7          |
| . Mumber born alive and                                | now living      |                       |                     |
| 6. Born alive but now dec<br>6. Number of children sti |                 |                       |                     |
| e number of children 201                               | . I ± D C I II  |                       |                     |
|                                                        | (Please write p | leinly)               | <del>-</del>        |
|                                                        |                 |                       |                     |
| Information with refe                                  | rance to        |                       | ith reference to    |
|                                                        |                 | <u>1/0"</u>           | <u>U Lik</u>        |
| Charlie Juso                                           | M. M. 20 S A/O  | Dona                  | Lummer              |
| (Full name)                                            |                 |                       | iden name)          |
|                                                        |                 | •                     | ٨                   |
| 4 4 6                                                  |                 |                       | 1)                  |
| mendian                                                |                 | merica                | liane               |
| Mludian (Rosidence)                                    |                 | (Re                   | sid ande)           |
| (Residence)                                            | ·               | (Re                   | sid ande)           |
| (Residence) ge at last birthday 5                      |                 | (Re Age at last birth | sid ande)           |
| (Rosidence) ge at last birthday 5                      |                 | (Re Age at last birth | sidence)<br>day 3 ( |
| (Rosidence) ge at last birthday 5                      |                 | (Re Age at last birth | sid ande)           |
| (Rosidence) ge at last birthday 5                      | <u>o.</u>       | (Re Age at last birth | sidance)<br>day 3 ( |

Thomsing you in advance for your coursesy in taking eare of this matter immediately in order that the record may be completed, I am,

Simperaly Yours,

lo K Macey

Special Agent, Buresu of the Census.

EBBPIVED AUG 8 1980 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH (If born in hospital or institution Prim. Registration District No. 2.155. Local Registrar's No. 1. give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of shild) Number Date of Legiti-Sex of Triplet mate? 465 birth or other? Child (To be answered only in event of plural births) (Month) Stillborn Born alive but now dead..... FULL Residence (Usual place of abode). 170 /36 Residence (Usual place of abode) 1000 If non-resident, give place and State..... It non-resident, give place and State..... Color or race White Color or race VY ALLC. Age at last Birthday..... (City and State or County) CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. \*Where there was no attending physician? or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

COLUMN TO THE TANK OF THE WATER AND IN THE TANK OF THE PARTY OF THE PA DIVERSITA TENED TO PLANT IN CERTIFICAÇÃO OF TURTH W ALE AND Heskits and Patrice Mo. tring Received Obstrict, No 10 Trees Received No. (If stillhold, sideritute the last total of these of thin) Nemper in the de la come d'étable de la commande d the state and to prevent (highlightle locationed According sumbler of colle of this mather, including present the the college and allow and com their Before but powdend the Dead land and Headeure Louis place of abuse .... It appriess better dien still bester very or rest total as Ann at last birerday, Years) Cultur or race think the age at last maning meshplace Comment Mild was Chinado to stail ban (117) Decupation Castal Aphlinghoods CENTERIOR OF ATTENDED THE PROPERTY OF MUDICIPAL 1 and a small Thereby could that I attended the birth of this child, who was subborn to the date short stated. for When there was no attending physician ; Committee of the Control of the Cont the and wife, then the lather, bouncholder, elec allebid make this return. A chilborn with the open that nothing breakfalls and White talks of the after with

STATE OF IDAHO RECEIVED Aliga PHYSICIAN t of OCCUPA 1930 DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH State File No..... County of Registration District No...... Local Registrar's No..... uld be stated EXACTLY, I classified. Exact statement Primary Registration District No..... (No. PERMANENT RECORD death occurred in a hospital or institution, give its name instead of street and number.) 2. FULL NAME. (a) Residence. No....(Usual place of abode) (If nonresident give city or town and State) How long in U. S., if of foreign birth? Length of residence in city or town where death occurred mos. Yrs. mos. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS Singlet Married, Widowed, Divorced (write the word) 16. DATE OF DEATH SEX 4. COLOR OF RACE should or Divo 5a. If married, widowed, or divorced HUSBAND of I HEREBY CERTIFY, That I attended deceased from AGE (or) WIFE of 6. DATE OF BIRTH (month, day and year 7. AGE Months Dave and that death occurred, on the date stated above, at min. 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer) (duration) \_\_\_\_\_yrs. \_\_\_\_mos. ds. CONTRIBUTORY (c) Name of employer (Secondary) (duration) yrs, mos, ds 9. BIRTHPLACE (city or town) 18. Where was disease contracted (State or country) if not at place of death? ... Did an operation precede death? W Date of 10. NAME OF FATHER Was there an autopsy? ..... 11. BIRTHPLACE OF FATHER (c (State or Country) import \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) 18. BIRTHPLACE OF MOTHER (city or 1 (State or Country) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Place of Burial, Cremation, or Removal Date of Burial Informan (Address) Address Registrar

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The guestion applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine. etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

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Do not accept a certificate of death signed only by a

midwife.

THE THE PERSON OF THE PARTY OF ELEMINATE OF WILLIAM A ...... A ...... The standard The court of The state of the s Miles in supportante the word Millainta of Command of child To the second to second the second to second t What producted to the production of the controlled the controlled to the controlled Sandan Commission of the Commi The angle of the second of the Mary and the second A STATE OF THE AUTOMOTION AND AUTOMOTION AUTOMOTIO number (Print) MACHE SE XVICHALMA DESIGNATION OF THE PROPERTY tradia avail: I hereby centify and a monday the phote of the all who was substant (aintenate) nebele the modern or western or releted ea, should make our education of the algorithm of the control of the control of the algorithm.

DIVISION OF VITAL STATISTICS DEPARTMENT OF COMMETCE BUREAU OF VITAL STATISTICS C.K. MACEY SPECIAL AGENT

Boise, Idaho

AUG 93 1030

## 183007

Mrs. I.N. Powell BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT. Jackson, Wyoming DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IEAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

| FULL NAME OF CHILD TEARLY I do                                                                                                                   | Al                        |                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------|
| PLACE OF DATE OF BIRTH Idaho Falls, Idaho LIPTH                                                                                                  | June 21, 1930             | SEX OF<br>CHILD Male |
| 1. Number of children born to this metho<br>2. Number born align and the living<br>3. Born alive but now dead<br>4. Number of children stillborn | er, including present     | birth 3              |
| (Please write p                                                                                                                                  | cleisty)  Information wit | h reference to       |
| Isaac hewto Powell                                                                                                                               | Hances We (Full maid      | Bloom Thou           |
| Jackson, Wyr<br>(Rosidence)                                                                                                                      | Jackson,                  | dande)               |
| Walla Walla, Wash.  (Birthelias)                                                                                                                 | Selma (                   | ala:                 |
| Rancher & Cattle-Chan                                                                                                                            | / High Se                 | hoof Teacher         |
|                                                                                                                                                  |                           |                      |

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

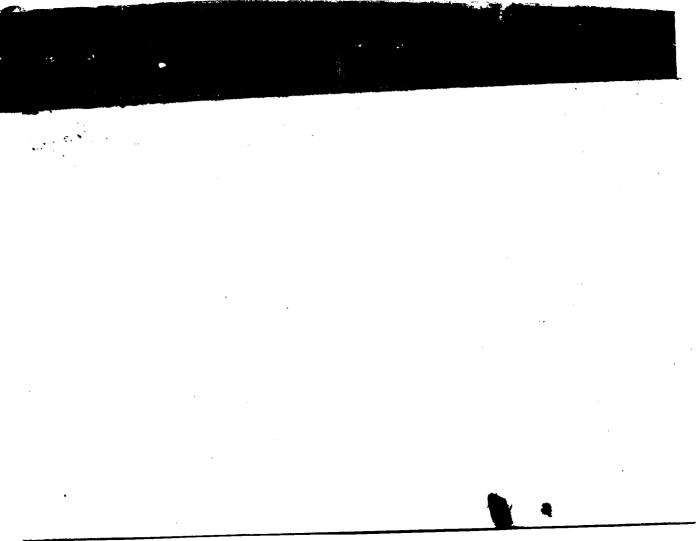
-C.K. Macey

Special Agent, Bireau of the Census.

ē. - a.



PARTMENT OF PURLICE BURNAU OF VITAL Registration District (If born in hospital or institution rim, Registration District No.2/10 Local Registrar's No. give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Twin Sex of Number Triplet Child in order Legiti. Date of or other? of birth mate? birth ..... (To be answered only in event of plural births) What prophylactic was used to prevent Ophthalmia Neonatorum? (Month Number of child of this mother, including present birth...... (a) Born alive but now dead......Stillborn Born alive and now living..... FULLMOTHER MAIDEN Residence (Usual place of abode 520 M. Water Residence (Usual place of abode) D20 V It non-resident, give place and State..... If non-resident, give place and State. Color or race Color or race. ...Age at last Birthday (Years) Birthplace . and State or County) City and State or County) Occupation Burns CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was Born alive on the date above stated. Stillborn (Signature). \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



| RECORD ed EXACTLY, PHYSICIANS Exact statement of OCCUPA.          | PLACE OF DEATH  County of City of Clark, Tull  (If death occurred in a hospital, or institution, give its second control of the county of the | DEATH  No. 2 1 D  Localdi Sistrar's No. 190  Loc |  |  |  |
|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| -6.73                                                             | (a) Residence. No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | St.  (If nonresident give city or town and State)  How long in U. S., if of foreign birth? yrs. — mos. — ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |
| NEN<br>sta<br>ied.                                                | Length of residence in city or town where death occurred. yrs. mos. ds.  PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |
| BINDING IS A PERMANENT AGE should be state properly classified. E | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)  5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 16. DATE OF DEATH  (Month) (Day) (Year)  17 JI HEREBY CERTIFY, That I attended deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |
| D FOR—THIS plied. A may be pate.                                  | 6. DATE OF BIRTH (month, day and year) 7. AGE Years Months Day If LESS than 1 day has or min. 8. OCCUPATION OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | that I ast saw h alive oz                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |
| ARGIN<br>UNFA<br>be car<br>terms, e                               | (a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer  9. BIRTHPLACE (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (duration)yrsmosds.  CONTRIBUTORY (Secondary)(duration)yrsmosds.  18. Where was disease contracted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |
| PLAINLY, nformation DEATH in See instru                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | if not at place of death?  Did an operation precede death?  Date of  Was there an autopsy?  What test confirmed diagnosis  Signed)  , M. D.  (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |
| WRITE  Every item of i                                            | 18. BIRTHPLACE OF MOTHER (atty or town) 11.  14.  Informant.  (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | *State the DISEASE CAUSING DEATH, to in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  19. Place of Burial, Cremation, or Removal  Date of Burial  19.  20. Undertaker  Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |
| N. B. should                                                      | 15. File 17.3 19.3 0 Regristrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | - Carrette  |  |  |  |

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Do not accept a certificate of death signed only by a midwife.

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PLACETICELYED AUG 1 2 1930 STATE OF IDAHO made for DEPARTMENT OF PUBLIC WELFARE RECORD County BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH PERMANENT RETURN must ceistration District No..... State File No. (If born in hospital or institution Prim. Registration District No. 2005 Local Registrar's No. 1. 34 give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Date of/ birth Sex of Legiti-Triplet in order SEPARATE IS A order of birtl Child or other? of birth birth matel (To be answered only in event of plural births) Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum?.. Number of child of this mother, including present birth \_\_\_\_\_\_\_(a) Born alive and now living Born alive but now dead... Stillborn ₩.5 FATHER MOTHER FULL each, FULL MAIDEN NAME NAME Residence (Usual place of shode) Residence (Usual place of abode) If nonresident, give place and State. If nonresident, give place and State. Age at last Birthday 2 Age at last Birthday Color or race. Color or race. (Years) Birthplace ... Birthplace (City and State or Country) (Sity and State or Country) Occupation ..... housewo Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was Stiffborn on the date above stated. \*Where there was no attending physician or midwife, then the father, householder, (Physician or-midwife etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. 7-30-1930 ż

WRITE PLAINLY, N. B.—Every item

## STATE OF IDAHO

## DECEIVED AIG 19 WIG DEPARTMENT OF PUBLIC WELFARE

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|         | PLACE                         | OF DEATH                                   | BUREAU OF VITAL S                        |                     | State File No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1373                  |
|---------|-------------------------------|--------------------------------------------|------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|
| C       | ounty of                      | Canyon                                     | CERTIFICATE OF                           | DEATH 7             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
|         | ity of Cal                    | _                                          | Registration District No                 |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 91                    |
| J       |                               |                                            | Primary Registration District            | No. 20              | Local Regis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | strar's No            |
|         |                               |                                            | (No                                      |                     | )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                       |
|         |                               | (If death occu                             | urred in a hospital or institution, give | its name instead of | of street and number.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | . M                   |
| 2.      | FULL NAM                      | ME Everett                                 | Ira Thompson                             |                     | ••                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 20*                   |
|         | (a) Reside                    | nce. No                                    |                                          | St                  | (If nonresident give city                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | or town and State.)   |
| Le      | (Usual<br>ength of resider    | place of abode.) ace in city or town where | death occured. yrs. mos.                 | ds. How long        | in U. S. if of foreign birth?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | yrs. mos. ds.         |
|         | PR                            | ERSONAL AND STATISTIC                      | AL PARTICULARS                           |                     | MEDICAL CERTIFICATE OF I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | DEATH                 |
| 8.      | SEX                           | 4. COLOR OR RACE                           | 5. Single, Married, Widowed,             | 16. DATE OF         | DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                       |
|         | Male                          | White                                      | or Divorced (write the word.)            | 21112 01            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <u> </u>              |
|         |                               |                                            |                                          |                     | July 29, 1930                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (Year)                |
| 58      | . If married, v<br>HUSBANI    | widowed, or divorced<br>) of               |                                          | 17 I HEREB          | Y CERTIFY, That I attended Acc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | essed from            |
|         | (or) WIFI                     |                                            |                                          | July                | 29, 19 30 to fee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Ly 29 , 1930          |
| 6.      | DATE OF BI                    | RTH (month, day and year)                  | July 29. 1930                            | that I last saw     | alive on                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 29 1930               |
| 7.      | AGE                           | Years Months I                             | Days If LESS than 1 day,                 | and that dea        | ath occurred, on the date stated                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | above, at 10 a.m.     |
|         | Mill.                         | boen -                                     | hrs. or                                  | *State the D        | ISEASE CAUSING DEATH, or i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | n deaths from VIOLENT |
| 8.      | OCCUPATION                    | N OF DECEASED                              | 1                                        | CAUSES, stat        | DISEASE CAUSING DEATH, or it<br>te (1) MEANS AND NATURE<br>DENTAL, SUICIDAL, or HOMIC<br>OF DEATH <sup>®</sup> was as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | IDAL.                 |
|         | (a) Trade, pr                 | ofession, or                               |                                          | The CAUSE O         | OF DEWILL MAS WE TOHOUS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       |
|         |                               | d of work                                  |                                          | " vis               | and the same of th |                       |
|         | business, or es               | nature of industry,<br>tablishment in      |                                          |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
|         | which employed<br>(c) Name of |                                            |                                          |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
|         |                               |                                            | ldwall Tacha                             |                     | (duration)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | yrsds.                |
| 9.      | (State or cou                 | E (city or town)                           | ldwell, Idaho                            | 11                  | ORY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                       |
| _       | 10 3713477 0                  | NE EARWED                                  |                                          | (Secondary          | )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                       |
|         | 10. NAME C                    | James                                      | Thompson                                 | II                  | (duration)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | yrsds. ds.            |
| , l     |                               |                                            |                                          | 18. Where wa        | as disease contracted place of death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                       |
| Z       | 11. BIRTHP<br>(State or       | LACE OF FATHER (city of Country)           | or town) Train Train SKA                 |                     | tion precede death? Da                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                       |
| PARENTS |                               | NAME OF MOTHER V                           | era Gallowsw                             | Was there an        | autopsy?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       |
| 4       |                               |                                            |                                          | What test co        | onfirmed magnotis?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <del>uu uu</del>      |
|         | 18. BIRTHP                    | LACE OF MOTHER (city                       | or town)Nebraska                         | Signed              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 70 00                 |
|         | (State of                     | r County)                                  |                                          | 7/29                | , 1930 (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | and /                 |
| 1       | 4.                            | James Tho                                  | mpson                                    | 19. Place of        | Burial, Cremation, or Removal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Date of Burial        |
|         | Informant<br>(Address)        |                                            | daho Rt #2                               |                     | anyon Hill                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 7-30- 198             |
| 1       | 5. Filed                      | -30-, 1930-                                | John Se meyer                            | 20. Undertak        | 2 & Case.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Address               |
| 1       | -                             |                                            | ( Negissiar.                             | . / -               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |

STATEMENT OF OCCUPATION.—Precise statement of o supation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient e. g., Farmer, Physician, Stenographer, C mpositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc, without more precise specifications, as Day laborer Farm laborer, Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Hous keepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidmic cerebrospinal meningitis"); Diptheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia"); Lobar Pneumonia: Bronchopneumonia ("pneumonia," unqualified, is indefite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of ...... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping Cough; Chronic valvular heart d'sease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

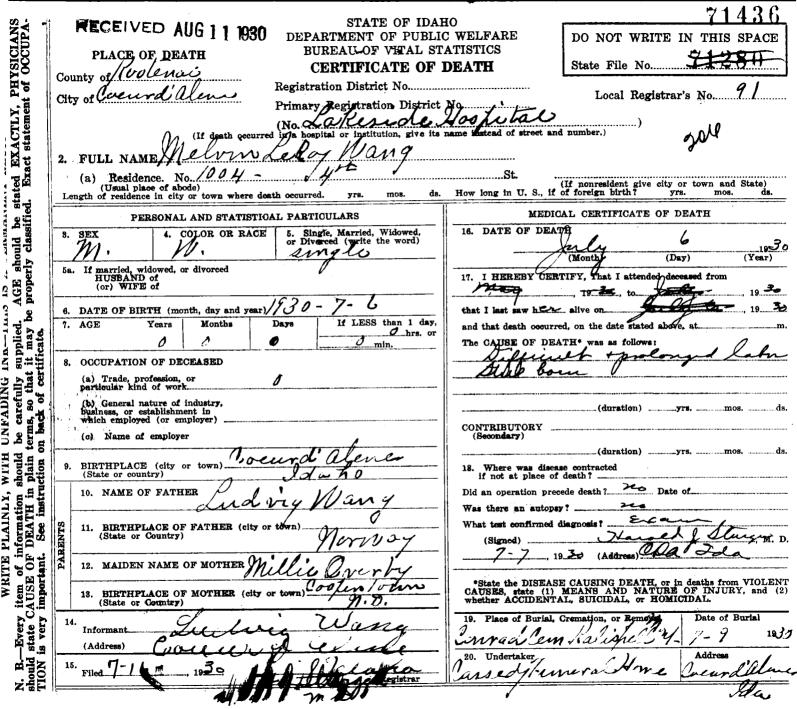
Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No. 3.0 State File No. (If born in hospital or institution Prim. Registration District No. / 5 Docal Registrar's No. / / give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of child) Number Twin Date of Legiti-Sex of in order and -Triplet hirth Child or other? mate? (Month) (Day) (To be answered only in event of plural births) (Year) What prophylactic was used to prevent Ophthalmia Neonatoyum? FIILL . FATHER MAIDEN FULL If non-resident, give place and State..... It non-resident, give place and State ......Age at last Birthday... Color or race. Birthplace ..... Birthplace .....! (Olty and State of County) Occupation Occupation ... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth.

THE ABOUT IT THE WAY A THE THE MAN THE STATE OF THE STATE HEALTH MANAGED TOTAL SELLENGE OF LEASE OF Print Series and District No. GLIEFE TO MEAN 3 of studying appoints for very substitute, for nones and appoint of Trongs to the myles because a dilmi.i (Manch) The prophylatic was used to provent Ophiladesis Nonuscorian? of parist of la se mother, tacheding present with white wife and now house STORES NA beet with that stee dead. HARHER The second secon otel has the print of the said Color or race remaind the state of last Birehard Age at test Birthday. folg sad seite ge County, (ceupaulen ... CERTIFICATE OF ATTENDED PHYSICIAN OF STARTITUS Therefore that I attended the birth of this child, who was Billham heta a synta sint of the Where there was no attending phraculation fall seeigt to amigle early se wid the then the maker, bearenquer, at a sign of the retorn A stablers 10g wedtered radden jedt 200 ff with Address many other evidence of life arter blith.



STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs. meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of ...... (name origin; "Cancer" is less definite: avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
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"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF

INJURY and qualify as ACCIDENTAL, SUICIDAL, or

HOMICIDAL, or as probably such, if impossible to de-

termine definitely. Examples: Accidental drowning;

struck by railway train-accident; Revolver wound of

head-homicide; Poisoned by carbolic acid-probably sui-

cide. The nature of the injury, as fractured skull, and con-

sequences (e. g. sepsis, tetanus) may be stated under the

head of "Contributory."

spinal fever (the only definite synonym is "Epidemic

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

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statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

| ENT RECORD<br>must be made for   | City of Salsus  No. St. 795-106-036-226 Registration Dist                                                                                                                                                                | STATE OF IDAHO ARTMENT OF PUBLIC WELFARE UREAU OF VITAL STATISTICS  CERTIFICATE OF BIRTH  crict No |  |  |  |  |  |
|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|--|--|--|--|
| PERMANENT RETURN must th stated. | FULL NAME OF CHILD Stillfirt                                                                                                                                                                                             | betitute the word "Stillbirth" for name of child)  Legiti-4 Date of Q                              |  |  |  |  |  |
| PER                              | Child function or other? (To be answered only in event of plural bi                                                                                                                                                      | mate? birth 1932 (Year)                                                                            |  |  |  |  |  |
| ARA er of                        | What prophylactic was used to prevent Ophthalmia Neo                                                                                                                                                                     | natorum?                                                                                           |  |  |  |  |  |
| SEPA<br>order                    | Number of child of this mother, including present birth 3 (a) Born alive and now living                                                                                                                                  |                                                                                                    |  |  |  |  |  |
| a Sin                            | Born alive but now dead                                                                                                                                                                                                  | Stillborn                                                                                          |  |  |  |  |  |
| birth a                          | FULL Sed Greg                                                                                                                                                                                                            | FULL MOTHER NAME SLOW                                                                              |  |  |  |  |  |
| at p                             | Residence (Usual place of abode) Mackey                                                                                                                                                                                  | Residence (Usual place of abode) Mackey                                                            |  |  |  |  |  |
| $\sim$                           | If nonresident, give place and State                                                                                                                                                                                     | If nonresident, give place and State                                                               |  |  |  |  |  |
|                                  | Color or race Age at last Birthday                                                                                                                                                                                       | Color or race AAge at last Birthday 22                                                             |  |  |  |  |  |
| n and                            | Birthplace (Years)                                                                                                                                                                                                       | Birthplace (Years)                                                                                 |  |  |  |  |  |
|                                  | Occupation (City and State or Country)                                                                                                                                                                                   | (Sity and State or Country)                                                                        |  |  |  |  |  |
| WITH<br>re than<br>and the       | CERTIFICATE OF ATTENDIN                                                                                                                                                                                                  |                                                                                                    |  |  |  |  |  |
| of more                          | I hereby certify that I attended the birth of this chi<br>on the date above stated.                                                                                                                                      | Born alive                                                                                         |  |  |  |  |  |
| WRITE PLA<br>N. B.—In case       | *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.  *Address: | (Physician or midwife)                                                                             |  |  |  |  |  |
| 4                                | ,                                                                                                                                                                                                                        | Registrar.                                                                                         |  |  |  |  |  |

PO

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|                              | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                   |  |  |  |  |  |
|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--|--|--|--|--|
| a.                           | PLACE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STATE OF IDAHO                                    |  |  |  |  |  |
| _\$                          | DEPA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ARTMENT OF PUBLIC WELFARE                         |  |  |  |  |  |
| RECORD<br>be made for        | I CONTINUE OF ACCUSE LEVEL TO THE TAXABLE OF THE PROPERTY OF T | JREAU OF VITAL STATISTICS                         |  |  |  |  |  |
| 8,9                          | City of hosting State,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                   |  |  |  |  |  |
| 選出                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CERTIFICATE OF BIRTH                              |  |  |  |  |  |
| <b>2,2</b>                   | No St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | O 183271                                          |  |  |  |  |  |
| TENT<br>must                 | 31.5 208 032.243 Registration Dist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | rict NoState File No                              |  |  |  |  |  |
|                              | (If born in hospital or institution                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 34                                                |  |  |  |  |  |
| NENT<br>N must               | give name.) Prim, Registration                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | n District NoLocal Registrar's No                 |  |  |  |  |  |
| <b>₹</b> ₩                   | FULL NAME OF CHILD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | no nome, Stell Truck                              |  |  |  |  |  |
| PERM<br>LETUE<br>1 state     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | estitute the word "Stillbirth" for name of child) |  |  |  |  |  |
| 를 를 받                        | Twin Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                   |  |  |  |  |  |
| 유유                           | Sex of and in order                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Legiti- Date of birth duy 19-30                   |  |  |  |  |  |
| TE pir                       | Child (To be answered only in event of plural b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                   |  |  |  |  |  |
| AT<br>F 1                    | <del>                                    </del>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7 3- 11                                           |  |  |  |  |  |
| SE                           | What prophylactic was used to prevent Ophthalmia Neo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | natorum V                                         |  |  |  |  |  |
| de PE                        | Number of child of this mother, including present birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (a) Born alive and now living                     |  |  |  |  |  |
| SEP.                         | Born alive but now dead                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Stillborn                                         |  |  |  |  |  |
| a.H                          | FATHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1/Amyreff )                                       |  |  |  |  |  |
| rth<br>ch,                   | FULL FULL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | FULL MAIDEN                                       |  |  |  |  |  |
| hirth                        | NAME USE COMMING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | NAME TOUS OFFICE                                  |  |  |  |  |  |
|                              | Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Residence (Usual place of abode)                  |  |  |  |  |  |
| DIN<br>ld at                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                   |  |  |  |  |  |
| e iid                        | If nonresident, give place and State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | If nonresident, give place and State              |  |  |  |  |  |
| UNFAD)<br>ne child<br>number | Color or race Muly Age at last Birthday 37                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Color or race Age at last Birthday 33             |  |  |  |  |  |
| UNF<br>one ch<br>numb        | (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (Years)                                           |  |  |  |  |  |
|                              | Birthplace (City and State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Birthplace (City and State or Cognitry)           |  |  |  |  |  |
| TTH<br>than<br>d the         | Occupation Dayman                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Occupation A ousewife                             |  |  |  |  |  |
| WITH<br>than                 | CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                   |  |  |  |  |  |
| P 2 5                        | CERTIFICATE OF ATTENDING PHISIOIAN OR MIDWIFE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                   |  |  |  |  |  |
| ILY V<br>more                | I hereby certify that I attended the birth of this chi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ld, who was Stillborn at                          |  |  |  |  |  |
| f III                        | on the date above stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | - CANA                                            |  |  |  |  |  |
| 70                           | (Sign                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ature)                                            |  |  |  |  |  |
| PLA<br>case                  | ( *Where there was no attending physician )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | - I / NIL 2/6                                     |  |  |  |  |  |
| • 1                          | or midwife, then the father, householder,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (Physician or midwife)                            |  |  |  |  |  |
| WRITE<br>B.—In               | etc., should make this return. A stillborn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (I hybridati pi marria)                           |  |  |  |  |  |
| 5                            | child is one that neither breathes nor Addre                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 988                                               |  |  |  |  |  |
| E B                          | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                   |  |  |  |  |  |
| z                            | Filed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Ung 1970 from tiller                              |  |  |  |  |  |
| F-1                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Registrar.                                        |  |  |  |  |  |

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A STATE OF THE PARTY OF THE PAR Prime Registrotton Digital Plans 2 17 10 Local Balling the lettered served and reverse and realisation monthly are THE PERSON What implicitly was north in principal their charles become commenced in Time Min evila mo ... Timiliti Berth affice but now death NAME L legione Limber shink If marketilent, pre plane and Super sometime trace with the slace and best to Signalized ... terms and state but we itelienopai) CERTIFICATE ATTEMPTARE PHYSICIAN I negotive courts chase I attended the birth of this child, who was Millione on the three distress states. ellinge there was no attending physician; the Property to Majoria Peror unidative shell the father, householder eic, should nake this retien A atlibut could be could that median organies nor shows other evidence of life after hirth, bolli

|                                                                                                |          | and the same of                                                              | <del>-</del> · · · · · · · · · · · · · · · · · · ·                       |                                               |  |  |
|------------------------------------------------------------------------------------------------|----------|------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------|--|--|
|                                                                                                |          | STATE OF I                                                                   |                                                                          | N. MILLO CD A CM                              |  |  |
| 20 T                                                                                           |          | RECEIVED AUG 5 1830 DEPARTMENT OF PUBL BUREAU OF VITAL S                     | IC WELFARE DO NOT WRITE I                                                |                                               |  |  |
| <b>A</b> 90.                                                                                   |          | PLACE OF DEATH CERTIFICATE OF                                                |                                                                          | 71491                                         |  |  |
| of Cir                                                                                         | Co       | unty of Registration District No                                             | <b>4.</b> 27 L                                                           | 17                                            |  |  |
| K XS                                                                                           | 001      | Primary Registration Distri                                                  |                                                                          | No                                            |  |  |
| 日<br>日<br>日<br>日                                                                               | Cit      | y 01. 6                                                                      | 100 140.45.45                                                            |                                               |  |  |
| tea .                                                                                          |          | (No(If death occurred in a hospital or institution                           | give its name instead instead of street and number.)                     |                                               |  |  |
| St. Is                                                                                         | 2.       | FULL NAME a Stil                                                             | (Birth)                                                                  | <i></i>                                       |  |  |
| RECORD<br>EXACT<br>Exact                                                                       |          |                                                                              | St                                                                       | • 1                                           |  |  |
|                                                                                                | l '      | (a) Residence. No. Handle Mill Mill Mill Mill Mill Mill Mill Mi              | (If nonresident give city of de. How long in U. S., if of foreign birth? | r town and State)                             |  |  |
|                                                                                                | Len      | ngth of residence in city or town where death occurred yrs. mos.             | de. How long in U. S., it of foreign birth?                              | yrs. 11108. ds.                               |  |  |
| PERMANENT RECORD should be stated EXACTLY, PHYSICIANS perly classified. Exact statement of 0Ç- |          | PERSONAL AND STATISTICAL PARTICULARS                                         | MEDICAL CERTIFICATE OF DE                                                | ATH                                           |  |  |
| NE<br>e si<br>ssij                                                                             | 3 4      | SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word) | 16 DATE OF DEATH                                                         | 3 .                                           |  |  |
| <b>₹</b> ₽₽                                                                                    | ļ        | male while                                                                   | July 20                                                                  | <u>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 </u> |  |  |
|                                                                                                | 50       | If married, widowed, or divorced                                             | (Month) (Day) (Year)                                                     |                                               |  |  |
| A PER<br>GE shoul<br>properly                                                                  | Ja       | HUSBAND of                                                                   | 17 I HEREBY CERTIFY, That I attended deceased from 20, 19 80 to          |                                               |  |  |
| A E S S                                                                                        | 1        | (or) WIFE of                                                                 |                                                                          |                                               |  |  |
| 3 H A . 3                                                                                      | 6        | DATE OF BIRTH (month, day and year)                                          | that I last saw h alive on                                               | 19                                            |  |  |
|                                                                                                | I        | AGE Years Months Days If LESS than                                           | and that death occurred, on the date stated above, at m.                 |                                               |  |  |
| THIS plied.                                                                                    |          |                                                                              | The CAUSE OF DEATH* was follows:                                         | 0 11                                          |  |  |
| ង . គ្រើកឹង                                                                                    | 8        | OCCUPATION OF DECEASED                                                       | Atter and elang                                                          |                                               |  |  |
|                                                                                                |          | (a) Trade, profession, or particular kind of work                            | 1                                                                        |                                               |  |  |
| ನ ಸ್ನಕ                                                                                         |          |                                                                              |                                                                          |                                               |  |  |
| Sefu<br>Sefu<br>Se t                                                                           |          | (b) General nature of industry,<br>business, or establishment in             | (duration) yrs mos ds.                                                   |                                               |  |  |
| 404                                                                                            |          | which employed (or employer)                                                 |                                                                          |                                               |  |  |
| UNFAI<br>UNFAI<br>be car<br>terms,                                                             | II       | (c) Name of employer                                                         | (Secondary)                                                              |                                               |  |  |
|                                                                                                | 9        | BIRTHPLACE (city or town) amureau tall                                       | (duration) yrs mos ds.                                                   |                                               |  |  |
| VITH<br>Should<br>plain<br>instr                                                               | <u> </u> | (State or country)                                                           | 18 Where was disease contracted if not at place of death?                |                                               |  |  |
| _ <b>≥</b> ″ _ a                                                                               |          | 10 NAME OF FATHER DA O                                                       | Did an operation precede death?                                          |                                               |  |  |
| ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~                                                          |          | Les & ahompson                                                               |                                                                          |                                               |  |  |
| PLAINLY<br>informati<br>? DEATH                                                                | S L      | 11 BIRTHPLACE OF FATHER (city or town) (State or country)                    |                                                                          |                                               |  |  |
| EA in E                                                                                        | ENT      | mo:                                                                          | (Signed)                                                                 | M. D.                                         |  |  |
| High P                                                                                         | PAR      | 12 MAIDEN NAME OF MOTHER                                                     | (Address)                                                                |                                               |  |  |
| E OF                                                                                           |          | - agnes Nave                                                                 | *State the DISEASE CAUSING DEATH, or                                     | in deaths from VIO-                           |  |  |
| SEL                                                                                            | .        | 13 BIRTHPLACE OF MOTHER (city or town) (State or country)                    | LENT CAUSES, state (1) MEANS AND NA                                      | TURE OF INJURY,                               |  |  |
| WRITE Vitem of CAUSE ( S very in                                                               | -        | 2 PAGILI                                                                     | and (2) whether ACCIDENTAL, SUICIDAL. or                                 | HOMICIDAL.                                    |  |  |
| 6 No. 8                                                                                        | 14       | Informant Teo Thompson                                                       | 19 Place of Burial, Cremation, or Removal                                | Date of Burial                                |  |  |
| Every state Con is                                                                             |          | (Address)                                                                    |                                                                          | 19                                            |  |  |
| ~   ~ =                                                                                        |          |                                                                              | 20. Undertaker                                                           | Address                                       |  |  |
| 8 % B.— B.— B.— IPAT                                                                           | 15       | Filed aug 4, 1930 Generien Nola                                              | .                                                                        |                                               |  |  |
| ~aE                                                                                            | ll l     | Registrar                                                                    |                                                                          | 1                                             |  |  |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer." 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DIS-EASE CAUSING DEATH (the primary affection with respect to time and causation), using aways the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtherla (avoid use of "Croup"); Typhoid fever (never report 'Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of ...... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," 'Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock, "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICID-AL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

## RECEIVED SEP 3 1830 -

DIVISION OF VITAL STATISTICS

DEPARTMENT OF COMMERCE BUREAU OF VITAL STATISTICS

C.K. MACEY SPECIAL AGENT

Boise, Idaho\_

AUG 23 1930

## 183356

Mrs. L.G. Thompson BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.

American Falls DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

| PLACE OF BIRTH American Falls                                                                  | DATE OF<br>BIRDS | July   | 20,  | 1930                         | SEX OF<br>CHILD       | Male                    |
|------------------------------------------------------------------------------------------------|------------------|--------|------|------------------------------|-----------------------|-------------------------|
| 1. Number of children born to the 2. Number born alive and new line 3. Porm alive but you have | ring             | r, inc | ludi | ng presen                    | it birth              | 5                       |
| <ol> <li>Born alive but now dend</li> <li>Number of children stillborn</li> </ol>              |                  |        | I_   |                              |                       |                         |
| (Please                                                                                        | e write p        | lsiniy | ,    | A 60                         | -                     | arm elektrone demonstra |
| Information with reference t                                                                   | 50               |        |      | mation wi<br>MOTH<br>ene Lav |                       | nce to                  |
| (Full name) American Fall: Idaho.                                                              | -                | Am     |      |                              | den name)<br>la Idaho | •                       |
| (Rosidence)                                                                                    |                  |        |      | (Res                         | idence)               |                         |
| Arto at last birthlag 37 Memphis Ne.                                                           | -                |        |      | st birthd<br>y Oregon        |                       |                         |
| (Birthplace)                                                                                   |                  |        |      |                              | rthplace)             |                         |
| (Occupation)                                                                                   | •                | neer.  |      |                              | -                     |                         |

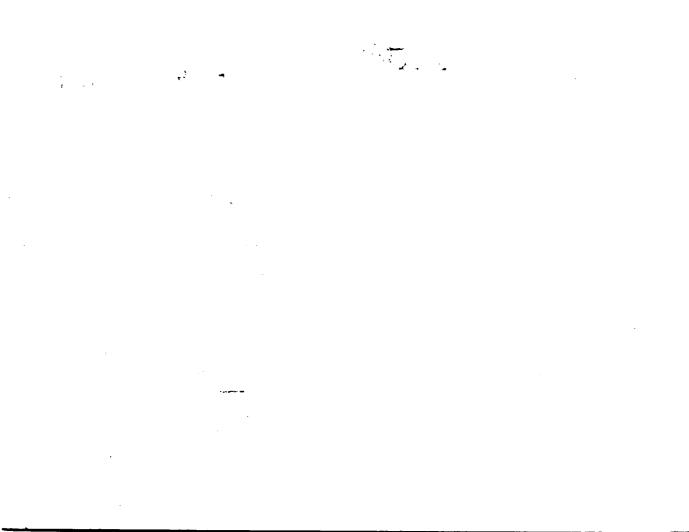
Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C.K. Macor

Special Agent, Bureau of the Census.

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FORM V. S. CERTIFICATE OF DEATH. State of Idaho , PHYSICIANS statement BOARD OF HEALTH Registration District No. . Bureau of Vital Statistics County Primary Registration District No 1085 File No. Registered No. I death occurs away from If death occurred in a hosusual residence, give facts called for under special pital, institution or camp, give its NAME instead of information. street and number. PERSONAL AND STATISTICAL PARTICULARS IFICATE OF DEATH 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED OWED OR DIVORCED. 16. DATE OF DEA 6. DATE OF BIRTH. (Month) (Dav) I HEREBY CERTIFY. That I attended deceased from (Month (Day) (Year 7. AGE IF LESS than 1 day Chat I last saw h. alive on how many ..... hrs. or and that death occured on the date stated above, at 3 Yrs. . . . . . Mos. . . . . . . . . . . . ds. .....min.? The CAUSE OF DEATH\* was as follows: 8. OCCUPATION (a) Trade, profession or particular kind of work... (b) General nature of industry, business, or estab-lishment in which employed (or employer)..... 9. BIRTHPLACE (Duration) Yrs, mos, Contributory (State or Country (Secondary) 10. NAME OF FATHER ....(Duration 11. BIRTHPLACE OF FATHER (State or Country) State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OF HOMICIDAL. 12. MAIDEN NAME OF MOTHE 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) 13. BIRTHPLACE OF MOTHER At place In the of death.....yrs.....mos.....days. State.....vrs.....mos..... (State or Country Where was disease contracted 14. THE ABOVE IS TRUE  $\mathbf{OT}$ if not at place of death?..... Former or (Informant) usual residence (Address) 15. 20. UND

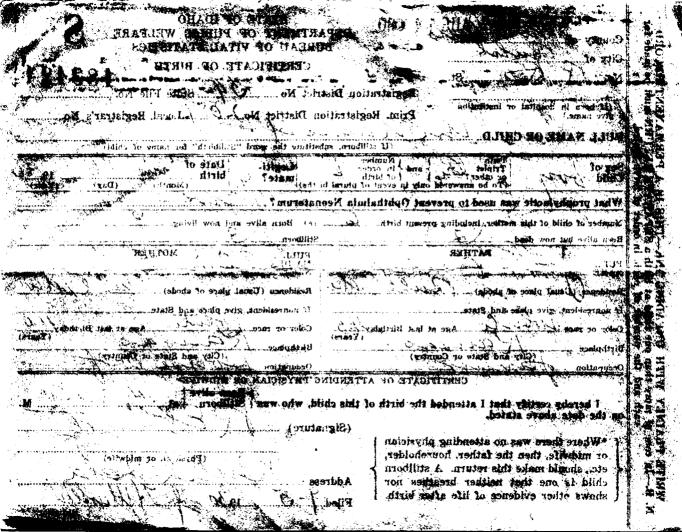
STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: Farmer (retired. 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, use of "Tumor" for malignant neoplasms: Measles: Whooping cough: Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere chopheumonia (secondary), 10 as. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Com," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUER-PERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train -accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory."

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE ANENT RECORD

Nust be made for County BUREAU OF VITAL STATISTICS City of Registration District No. State File No .... (If born in hospital or institution Prim. Registration District No. 2. 02 Local Registrar's No..... give name.) FULL NAME OF CHI (If stillborn, substitute the word "Stillbirth" for name of child) Number Date of Sex of Legitiin order mate? 40 birth Child (To be answered only in event of plural births) (Month) What prophylactic was used to prevent Ophthalmia Neonatorum? SEP/ Number of child of this mother including present birth..... (a) Born alive and now living Born alive but now dead... FATHER MOTHER FULL FILL. MAIDEN NAME .. Residence (Usual place of abode) Residence (Usual place of abode) If nonresident, give place and State If nonresident, give place and State at last Birthday Color or race one Birthplace Birthplace. (City and State or Country) (City and State or Country Occupation Occupation and CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* PLAINLY I hereby certify that I attended the birth of this child, who was I Stillborn on the date above stated. (Signature) case \*Where there was no attending physician or midwife, then the father, householder, WRITE B.—In c etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Registrar.



| 2                                           | STATE OF IDA                                                                 | HO                                                                                                                                                            |  |  |  |  |
|---------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| PHYSICIANS: of OCCUPA-                      | RECEIVED JUL 5 1930 DEPARTMENT OF PUBLIC                                     |                                                                                                                                                               |  |  |  |  |
| 55                                          | PLACE OF DEATH BUREAU OF VITAL ST                                            | ATISTICS 7 1 2 4                                                                                                                                              |  |  |  |  |
|                                             | CERTIFICATE OF                                                               | DEATH State File No                                                                                                                                           |  |  |  |  |
| H &                                         | County of Registration District No                                           | 04                                                                                                                                                            |  |  |  |  |
| EECORD<br>EXACTLY, I                        | City of Primary Registration District                                        | No. 2027 Local Registrar's No                                                                                                                                 |  |  |  |  |
| O T E                                       | (No                                                                          | )                                                                                                                                                             |  |  |  |  |
| RECORD<br>EXACT<br>ract state               | death occurred in a hospital or institution, give its                        | restanced of street and number.)                                                                                                                              |  |  |  |  |
| c EX                                        | 2. FULL NAME SATY DE AN                                                      | $\gamma$                                                                                                                                                      |  |  |  |  |
| # <b></b> #                                 | (a) Residence. No.                                                           | St.                                                                                                                                                           |  |  |  |  |
| ENT B<br>stated                             | (Henel place of shode)                                                       | (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.                                                            |  |  |  |  |
| NG PERMANENT hould be state y classified. E | PERSONAL AND STATISTICAL PARTICULARS                                         | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |  |  |  |  |
| M.A.<br>I. b.<br>Issi                       | 4. COLOR OR RACE 5. Single Married, Widowed,                                 | 16. DATE OF DEATH                                                                                                                                             |  |  |  |  |
| ING<br>PERI<br>should<br>rly clas           | or Divorted (write the word)                                                 | June 16- 1,30                                                                                                                                                 |  |  |  |  |
| N de t                                      | 5a. If married, widowed, or divorced                                         | (Month) (Day) (Year)                                                                                                                                          |  |  |  |  |
| BINDIN<br>IS A F<br>AGE sh<br>properly      | HUSBAND of (or) WIFE of                                                      | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                           |  |  |  |  |
| BIN<br>S IS A<br>AGE<br>prope               | 1/1920                                                                       | 19 10 10 11 19                                                                                                                                                |  |  |  |  |
| FOR LAIS                                    | 6. DATE OF BIRTH (month, day and year) / / / / / / / / / / / / / / / / / / / | that I last saw h alive on, 19                                                                                                                                |  |  |  |  |
| te ged H                                    | hrs. or                                                                      | and that death occurred, on the date stated above, at                                                                                                         |  |  |  |  |
| A G S                                       | min.                                                                         | The CAUSE OF DEATH* was as follows:                                                                                                                           |  |  |  |  |
| 罗日 第三章                                      | 8. OCCUPATION OF DECEASED                                                    | Fre natal death                                                                                                                                               |  |  |  |  |
| SSE<br>SEPA                                 | (a) Trade, profession, or particular kind of work                            |                                                                                                                                                               |  |  |  |  |
| RES<br>DIN<br>refull<br>80 th               | (b) General nature of industry,<br>business, or establishment in             | (duration) yrs, mos. ds,                                                                                                                                      |  |  |  |  |
| E E E E                                     | which employed (or employer)                                                 | CONTRIBUTORY Cottreme Obesily of                                                                                                                              |  |  |  |  |
| RGIN<br>UNF<br>be c<br>erms                 | ''(c) Name of employer                                                       | (Secondary)                                                                                                                                                   |  |  |  |  |
| MAR<br>H U<br>ld b<br>ln te                 | a both dissections but have a configuration of the second                    | (duration) yrs. mos. ds.                                                                                                                                      |  |  |  |  |
| MANTH<br>WITH<br>Should<br>plain<br>ction   | 9. BIRTHPLACE (city or town) (State or country)                              | 18. Where was disease contracted if not at place of death?                                                                                                    |  |  |  |  |
| rac                                         | 10. NAME OF FATHER A Q                                                       | Did an operation precede death? Date of                                                                                                                       |  |  |  |  |
| T.Y.                                        | to Japlu                                                                     | Was there an autopsy?                                                                                                                                         |  |  |  |  |
| PLAINLY<br>nformation<br>DEATH<br>See inst  | 11. BIRTHPLACE OF FATHER (city or town) (State or Country)                   | What test confirmed diagnosis?                                                                                                                                |  |  |  |  |
| T fee                                       | Kanear                                                                       | (Signed) (Signed) (M. p.                                                                                                                                      |  |  |  |  |
|                                             | (State or Country)  12. MARDENYNAME OF MOTHER                                | , 19 (Address) Sufil do                                                                                                                                       |  |  |  |  |
| WRITE<br>item of i<br>AUSE OF<br>important. |                                                                              |                                                                                                                                                               |  |  |  |  |
| WI WI                                       | 13. BIRTHPLACE OF MOTHER (city or town) (State or Country)                   | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |  |  |  |  |
| <i>T</i> 1                                  | 1 / yangar                                                                   |                                                                                                                                                               |  |  |  |  |
| P P                                         | 14. Informant & Wamply                                                       | 19. Place of Burial, Cremation, or Removal Date of Barial                                                                                                     |  |  |  |  |
| -Ever<br>state<br>is ver                    | (Address) Sul Hahd                                                           | suffxemeting 6/16 30                                                                                                                                          |  |  |  |  |
| ļ. <del></del> .[                           | 15. 1-1/ 70 /// // w. fly                                                    | Address Address Address                                                                                                                                       |  |  |  |  |
| F. B. Hould                                 | Filed ( , 1920. , Registrar                                                  | Mourle of use Duch she                                                                                                                                        |  |  |  |  |
| A 100 E                                     |                                                                              | ~ 5/7/                                                                                                                                                        |  |  |  |  |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine. etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

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DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

PLACE OF BIRTH STATE OF IDAHO County of BRECEIVE DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH ARATE RETURN must No. St. antheny st. Registration District No. State File No..... Hosa -(If born in hospital or institution Prim. Registration District No. Local Registrar's No. 7944 give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Number Twin Date of Legiti-Sex of and din order Triplet mate? yes birth ... temale Child ' or other? (To be answered only in event of plural births) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead ........Stillborn ..... FILL MOTHER FATHER MAIDEN NAME KAY H LOGIKEY NAME Residence (Usual place of abode) 1045 E. Freeman child Residence (Usual place of abode) 1845 E France 1 If non-resident, give place and State..... It non-resident, give place and State M: (Years) (City and State or County) (City and State or County) Occupation Occupation Ending CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* Born alive I hereby certify that I attended the birth of this child, who was Stillborn. case of on the date above stated. \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth.

The president medical action of a light of White to the old in amorate state to stone ?

Storist ages. District Me diorn in hand for including CHARLES NAMED OF CHILD OF THE CO. Tage Treduction 17 of 11 19 17 (ii) ASSE with to The State ( the true of the boundary of all ) Same paying make paint or property the former of the same of the s med tab .... on measure uniquent reduce alor o mary to estampe . DROD THE TOT OFFICE A HIGH ) GUHTHE Beringer Paul Rengel open The way do not be to the state The selection of the selection THE THE UNITED SENTE L. weinder B. TALL MANAGEMENT AND THE STATE OF THE STATE O Mile Care Care . A Bridge Body SALEMOIN SHO MAPRICATE CONTRACTOR OF STREET, CONTRACTOR in the small Thereby confits that I attracted the facilities and the thereby confit that I attracted the facilities and dentitie on the other winters. Lower thing was no attendition therefore date need with the course of the bear ried. tele confibered the porce A still and

| <b>8</b> .                                                    | 1                                                                        | BECE!                                                                                                  | VED SEP 10                           | 1930            | STATE                                                                                       | OF IDA                                              | HO                                                    |                                            |                                                            |  |  |
|---------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------|--------------------------------------------|------------------------------------------------------------|--|--|
| PHYSICIANS<br>of OCCUPA-                                      |                                                                          | 1120-                                                                                                  | <b>0</b>                             | DEPAR           |                                                                                             |                                                     | C WELFARE                                             | DO NOT WRIT                                | E IN THIS SPACE                                            |  |  |
| 55                                                            | PLACE OF DEATH  County_of Bannock  BUREAU OF VITAL STA  CERTIFICATE OF D |                                                                                                        |                                      |                 | TATISTICS                                                                                   |                                                     |                                                       |                                            |                                                            |  |  |
| YS                                                            |                                                                          |                                                                                                        |                                      |                 |                                                                                             | State File No                                       | 715                                                   |                                            |                                                            |  |  |
| HA<br>S                                                       | li                                                                       | Dog                                                                                                    | atello                               | Registrat       | ion District                                                                                | t No. ユ                                             | <u> </u>                                              |                                            | ~ C C C Z                                                  |  |  |
|                                                               | C                                                                        | ity ofPUG                                                                                              |                                      | Primary         | Registratio                                                                                 | n District                                          | No. 2 16 /                                            | Local Regist                               | rar's No.5883                                              |  |  |
|                                                               |                                                                          |                                                                                                        |                                      | (NoS            | t. Ant                                                                                      | hony,s                                              | Hospital                                              | )                                          |                                                            |  |  |
| ORD<br>ACTLY,<br>statement                                    |                                                                          |                                                                                                        |                                      |                 |                                                                                             | ion, give its                                       | name instead of street and                            | number.)                                   | 206                                                        |  |  |
|                                                               | 2.                                                                       | FULL NAM                                                                                               | E                                    | Ann Wal         |                                                                                             | ·····                                               |                                                       |                                            | 0                                                          |  |  |
| ~ <del></del> ×                                               |                                                                          | (a) Residen                                                                                            | ice. No. Po                          | ocatello        | , Ida                                                                                       | ho.                                                 | St                                                    |                                            |                                                            |  |  |
| tate ]                                                        | L                                                                        | (Usual place<br>ength of residence                                                                     | e of abode)<br>in city or town where | death occurred. | yrs.                                                                                        | mos. ds.                                            | How long in U. S., if o                               | If nonresident give ci<br>f foreign birth? | ty or town and State) yrs. mos. ds.                        |  |  |
| DING<br>A PERMANENT<br>should be stated<br>erly classified. E |                                                                          | PER                                                                                                    | SONAL AND STATIST                    | TCAL PARTICI    | IT.ARS                                                                                      |                                                     | MEDICA                                                | AL CERTIFICATE O                           | 7 DEAMH                                                    |  |  |
| MA<br>by by                                                   | 8.                                                                       | . SEX                                                                                                  | 4. COLOR OR RAC                      |                 | , Married, W                                                                                | idowed.                                             | 16. DATE OF DEAT                                      | · · · · · · · · · · · · · · · · · · ·      | DEATH                                                      |  |  |
| ING<br>PERN<br>should                                         | Fe                                                                       | emale                                                                                                  | White                                | or Divorc       | ngle the                                                                                    | e word)                                             | Aug                                                   | gust 15                                    | , 1930.                                                    |  |  |
| NI de la                                                      |                                                                          | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                           |                                      |                 |                                                                                             | M 1000 100 100 100 100 100 100 100 100 1            | (Month)                                               | (Day) (Year)                               |                                                            |  |  |
|                                                               |                                                                          |                                                                                                        |                                      |                 |                                                                                             | 17. I HEREBY CERTIFY, That I attended deceased from |                                                       |                                            |                                                            |  |  |
| BIN<br>S IS<br>AGE<br>prop                                    |                                                                          |                                                                                                        |                                      | 3070            | - 8-15, 1930, to 8-15, 193                                                                  |                                                     |                                                       |                                            |                                                            |  |  |
| FOR J.THIS led. A ty be I.e.                                  |                                                                          | 6. DATE OF BIRTH (month, day and year) August 15, 1930. 7. AGE Years Months Days If LESS than 1 day.   |                                      |                 | that I last saw h alive on, 19                                                              |                                                     |                                                       |                                            |                                                            |  |  |
|                                                               | - 11                                                                     | ill-born                                                                                               | , ears Mondia                        | Days            |                                                                                             | hrs. or                                             | and that death occurred, on the date stated above, at |                                            |                                                            |  |  |
| RVED<br>INK-<br>suppl<br>it m                                 | -                                                                        | min.                                                                                                   |                                      |                 | The CAUSE OF DEATH* was as follows:                                                         |                                                     |                                                       |                                            |                                                            |  |  |
|                                                               | 8                                                                        | 8. OCCUPATION OF DECEASED                                                                              |                                      |                 |                                                                                             | Still-birth due to                                  |                                                       |                                            |                                                            |  |  |
| ESER<br>NG<br>ully<br>that                                    |                                                                          | (a) Trade, profession, or None particular kind of work                                                 |                                      |                 |                                                                                             |                                                     |                                                       |                                            |                                                            |  |  |
|                                                               |                                                                          | (b) General nature of industry, business, or establishment in Infant                                   |                                      |                 |                                                                                             | (duration) vrs. mos.                                |                                                       |                                            |                                                            |  |  |
| MARGIN RESE 'H UNFADING 'Id be carefully in terms, so that    |                                                                          | which employed                                                                                         | (or employer)                        |                 | THIANG                                                                                      |                                                     | CONTRIBUTORY                                          | • • • • • • • • • • • • • • • • • • • •    | дгв                                                        |  |  |
| ARGI<br>UNI<br>be<br>term                                     |                                                                          | (c) Name of                                                                                            | employer                             |                 |                                                                                             | ļ                                                   | (Secondary)                                           |                                            |                                                            |  |  |
| MA<br>ITH<br>ould<br>ain<br>on o                              |                                                                          | DIDTUDI ACU                                                                                            | (altr. on town)                      | Pocatel         | lo, I                                                                                       | daho.                                               | 44.44.44.44.44.44.44.44.44.44.44.44.44.               | (duration)                                 | yrsds.                                                     |  |  |
| WITH<br>WITH<br>should<br>plain<br>ction                      |                                                                          | 9. BIRTHPLACE (city or town) 100da oction; Idano. (State or country)  10. NAME OF FATHER Ray H. Walker |                                      |                 | 18. Where was disease contracted if not at place of death?  Did an operation precede death? |                                                     |                                                       |                                            |                                                            |  |  |
| M<br>NLY, WITH<br>ation should<br>TH in plain<br>instruction  |                                                                          |                                                                                                        |                                      |                 |                                                                                             |                                                     |                                                       |                                            |                                                            |  |  |
| PLAINLY<br>nformation<br>DEATH i                              |                                                                          |                                                                                                        |                                      |                 |                                                                                             |                                                     | Was there an autopsy                                  | - 200                                      |                                                            |  |  |
| EAT AI                                                        | TIS                                                                      | 11. BIRTHPLA<br>(State or Co                                                                           |                                      | •               |                                                                                             |                                                     | What test confirmed dip                               | 9870016?                                   |                                                            |  |  |
| I Pig                                                         | PARENTS                                                                  |                                                                                                        |                                      |                 | ssouri                                                                                      | •                                                   | (Signed)                                              | Do                                         | catello, Ida                                               |  |  |
| of Cant                                                       | PA                                                                       | 12. MAIDEN N                                                                                           | NAME OF MOTHER FO                    | eda Sch         | mid                                                                                         |                                                     | 0/10/30 • , <sub>19</sub>                             | (Address) FU                               | Galerro, Ida                                               |  |  |
| WRITE<br>em of i<br>ISE OF<br>portant.                        |                                                                          |                                                                                                        | CE OF MOTHER (city                   |                 |                                                                                             |                                                     | *State the DISEASE                                    | CAUSING DEATH. or                          | in deaths from VIOLENT                                     |  |  |
| WRITE F<br>item of in<br>CAUSE OF I                           |                                                                          | (State or Co                                                                                           | ountry)                              | Paris,          | Idaho                                                                                       | •                                                   | CAUSES, state (1) M<br>whether ACCIDENTAL             | EANS AND NATUR<br>, SUICIDAL, or HOM       | in deaths from VIOLENT<br>E OF INJURY, and (2)<br>IICIDAL. |  |  |
| ~ ~ ~                                                         | 14                                                                       | 4.                                                                                                     | Ray H. Wall                          | ker             |                                                                                             |                                                     |                                                       |                                            |                                                            |  |  |
| -Every<br>state (<br>is very                                  |                                                                          | IIIOI IIIaii                                                                                           |                                      |                 | <b>X</b> -                                                                                  |                                                     | 19. Place of Burial Cr<br>Mountain Vie<br>Pocatello   | ew Cemetery                                | 8/16/30.19                                                 |  |  |
| (                                                             | -                                                                        |                                                                                                        | 45 East Fred                         | man St          | Hoca.                                                                                       | Ida.                                                | 20. Undertaker                                        | , Iuano.                                   | Address                                                    |  |  |
| N. B.<br>Tionic                                               | 10                                                                       | $_{\text{Filed}} 8/16$                                                                                 | /30 • 19                             | AVA             | ull                                                                                         | 1-                                                  | Arthur                                                | W. Hall                                    | Pocatello                                                  |  |  |
| ZÆE                                                           | 1                                                                        |                                                                                                        |                                      |                 |                                                                                             | <b>Ris</b> trar                                     |                                                       |                                            |                                                            |  |  |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The guestion applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

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Do not accept a certificate of death signed only by a

midwife.

212-275.006-PLACE OF EGENVE 1930 STATE OF IDAHO County of Binah DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Ño. Registration District No..... State File No..... (If born in hospital or institution Prim. Registration District No. A. C. Z. Local Registrar's No. give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of child) Number \ Date of Legitiin order Sex of and Triplet mate? Child " (To be answered only in event of plural birtha) (Month) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth...... (a) Born alive and now living...... )\_\_\_\_\_Stillborn \_\_\_\_\_\_ Born alive but now dead...... FULL MAIDEN Residence (Usual place of abode)... Residence (Usual place of abode). 1. If non-resident, give place and State It non-resident, give place and Mate Color or race Birthplace ...... Birthplace ...... (City and State or County) (City and State or County) Occupation ..... -dustes Occupation ..... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. \*Where there was no attending physician? or midwife, then the father, householder, (Physician or miceetc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

7.757 Maria Salar Maria HTHLE OF A HERE e Frim Registration Obertal No. OF CHARLES TO SHARE THE CITY OF THE CITY OF THE CITY OF THE CASE OF THE CITY O reduced nierrand reduced to control to the treatment to t od only it come or chiral hintes (Liny) properties with used to prevent Opertulate Neonator and Junear of child of this mother including present birth ...... ment alive but now don't MOTHEOM PATHER MANUEL STATES AND A STATES OF THE STATES OF Residence Lines in de land If non-ratidents give place and firsts. med being ober and Italian (4100 T) Helicant the out the first to the total Chimping Chip and the or Country) Birtinineo City and Male in Country) Gornipation ..... September 1 CERTIFICATE OF ATTENDERS PHYSICIAN OF MILETER. out the date above stated. forthere there was up attending physician Problem of mad of milwite then the lather, homeholder, electioneld make this return. A stillborg dilid is one that unither breathes nor shows other extence of life after birth.

| ENT RECORD stated EXACTLY, PHYSICIANS d. Exact statement of OCCUPA-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | PLACE OF DEATH County of Graphic City of Blackfield  2. FULL NAME (a) Residence. No.                             | 1930 STATE OF IDAR DEPARTMENT OF PUBLIC BUREAU OF VITAL ST.  CERTIFICATE OF I Registration District No | C WELFARE ATISTICS DEATH 3                                                              | DO NOT WRITE IN THIS SPACE State File No                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ERMANENT<br>uld be stated<br>classified. E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (Usual place of abode) Length of residence in city or town where de                                              |                                                                                                        | How long in U. S., if of                                                                |                                                                                                                                                                                                                                                                                                                                                                          |
| GERMANER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | PERSONAL AND STATISTIC  8. SEX  4. COLOR OR RACE                                                                 | 5. Single, Married, Widowed, or Phyorced (write the word)                                              | 16. DATE OF DEATH                                                                       | L CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                   |
| BINDING S IS A PERM AGE should properly class                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                     | Single                                                                                                 |                                                                                         | (Month) (Day) (Year)  PFY, That I attended deceased from                                                                                                                                                                                                                                                                                                                 |
| rOR<br>THIS<br>ied.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. DATE OF BIRTH (month, day and year) 7. AGE Years Months                                                       | Days /If LESS than 1 day,<br>hrs. or                                                                   | and that death occurred                                                                 | alive on the date stated above, at m.                                                                                                                                                                                                                                                                                                                                    |
| EKVED FOR INK—THE SUBDIFIED IN SUPPLIED IN | 8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work.                                    |                                                                                                        | The CAUSE OF DEATH* was as follows:                                                     |                                                                                                                                                                                                                                                                                                                                                                          |
| KGIN KESI<br>UNFADING<br>be carefully<br>erms, so the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer |                                                                                                        | CONTRIBUTORY (Secondary)                                                                | (duration) yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                 |
| WITH<br>Should<br>plain<br>ction                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 9. BIRTHPLACE (city or town) (State or country)                                                                  | ackfort, 2d                                                                                            | 18. Where was disease if not at place of d                                              | contractedeath?                                                                                                                                                                                                                                                                                                                                                          |
| PLAINLY, Vinformation s<br>DEATH in See instruc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 10. NAME OF FATHER  11. BIRTHPLACE OF FATHER (city of (State or Country)  12. MAIDEN NAME OF MOTHER              | E. Baker<br>town Lumas                                                                                 | Did an operation preced<br>Was there an autopsy?<br>What test confirmed dis<br>(Signed) | le death? W Date of                                                                                                                                                                                                                                                                                                                                                      |
| WRITE<br>em of<br>USE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 12. MAIDEN NAME OF MOTHER  13. BIRTHPLACE OF MOTHER (city of (State or Country)                                  | nae Dodge                                                                                              | *State the DISEASE<br>CAUSES, state (1) M                                               | CAUSING DEATH, or in deaths from VIOLENT EANS AND NATURE OF INJURY, and (2), SUICIDAL, or HOMICIDAL.                                                                                                                                                                                                                                                                     |
| Every it state CA is very in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 14. Informant Raymond (Address) R. D. 200                                                                        | E Baker                                                                                                |                                                                                         | emation, or Removal  Date of Burish  130  141  Date of Burish  183  184  Date of Burish  185  Date of Burish  185  Date of Burish  187  Date of Burish |
| N. B.—should a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 15. Filed Lay 20, 1931 M                                                                                         | Maker E. Satte                                                                                         | 20. Undertaker Cle                                                                      | Baker Impu Saho                                                                                                                                                                                                                                                                                                                                                          |

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RECEIVED SFP & 1930 PLACE OF BIRTH STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of Janakam BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No. .....State File No...... (If born in hospital or institution Local Registrar's No. Prim. Registration District No.... give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of shild) Number in order Date of Legitiand Triplet hirth mate? Child 0 or other? (To be answered only in event of plural births)) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? FULL MAIDEN MOTHER Residence (Usual place of abode).... it non-resident, give place and State If non-resident, give place and State... Color or race May Age at last Birthday ....Age at last Birthday... Birthplace ...... Birthplace ..... (City and State or County) (Cay and State or County) Occupation ..... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. at 10:00 I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. \*Where there was no attending physician? or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

TAKE OF A DEL ARTHURST OFFICE DESTRUCTION OF THE PROPERTY OF PARAL PORTO Registration Wester No. notherinal so talle the at any Print Registration District No. 214 Page 114 Printers THE OF CHILD thing to sense to "attitude to were the application of coulding the nation of bon Loudin 43.880 a. dritto Their property was used to provent Ophibalula Nonataluary the or celled of this includes present with Stillberg deet will the wall now done. SHOTOK KATHEL The state of the s Residence things place of abode it non-inflicent, give place and the and the same and the section was The is now I the Are in the Bromon Time Color or rave Line Acc 21 last Birthday COUNTY TO STAND BILL VALUE OF STANDARD IN Birthbiace ... (CON MICH SECURITY) ... Dallagueric EDIT AUBERTON CERTIFFIATE, OF ATTRIBUTION PHENICIAN OF MINWIFE. I have could that I attended the hirth of this child, who was Stillbernshove stated. Principles there was no attenues thereigns They were the work of the or nitreth than the father, househelder. etc. etend neste the teren. A editory the street was an expensive region to the

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH State File No..... Registration District No..... Local Registrar's No. Primary Registration District No. (No. RECORD death occurred in a hospital or institution, give its name instead of street and number.) stated (a) Residence. No..... PERMANENT (Usual place of abode) (If nonresident give city or town and State) How long in U. S., if of foreign birth? Length of residence in city or town where death occurred. mos. yrs. mos. classified. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 16. DATE OF DEATH Single, Married, Widowed, SEX 5. plnous Divorced (write the word) 5a. If married, widowed, or divorced HUSBAND of That I attended deceased from (or) WIFE of 6. DATE OF BIRTH (month, day and year) Months Days If LHSS 7. AGE hat it may certificate. and that death occurred, on the date stated above, at 1.1 The CAUSE OF DEATH\* was as follows min. 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer) CONTRIBUTORY (c) Name of employer (Secondary) (duration) yrs. mos. should OF DEATH in plain ant. See instruction 9. BIRTHPLACE (city or town). Where was disease contracted if not at place of death? 18. (State or country) Did an operation precede death? Date of Was there an autopay? BIRTHPLACE OF FATHER What test confirmed diagnosis (State or Country) AUSE OF important. 12. MAIDEN NAME OF MOTE \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) 13. BIRTHPLACE OF MOTHER (city (State or Country) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Place of Burial, Cremation, or Removal Date of Burial Informant (Address) Registrar

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head-homicide; Poisoned by carbolic acid-probably sui-

cide. The nature of the injury, as fractured skull, and con-

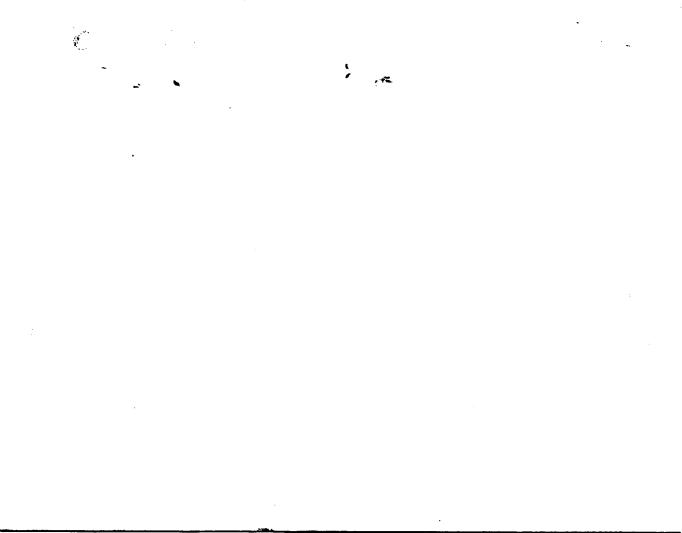
sequences (e. g. sepsis, tetanus) may be stated under the

Do not accept a certificate of death signed only by a

midwife.

head of "Contributory."

PLACE OF RECORD be made for STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS City of. CERTIFICATE OF BIRTH 183656 -THIS IS A PERMANENT SEPARATE RETURN must order of birth stated. Registration District No..... State File No. (If born in hospital or institution Prim. Registration District No. 202 Local Registrar's No. give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Date of Legiti-Triplet in order birth or other? of birth mate? (To be answered only in event of plural births) (Month) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth... \_\_\_\_ (a) Born alive and now living Born alive but now dead\_ Stillborn FATHER FULL birth each, FULL MAIDE NAME I UNFADING one child at bi e number of ea Residence (Usual place of abode) Residence (Usual place of abode) If nonresident, give place, and State If nonresident, give place and State Age at last Birthday. Color or race Color or rac at last Birthday Birthplace Birthplace. (City and State or Country) City and State d Country) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE ch an Born alive: I hereby certify that I attended the birth of this child, who was \ Stillbern on the date above stated. (Signature) \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, WRITE etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth.



STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs. use of "Tumor" for malignant neoplasms; Measles; Whooping cough: Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.: Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Start," "The start of the start of th "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

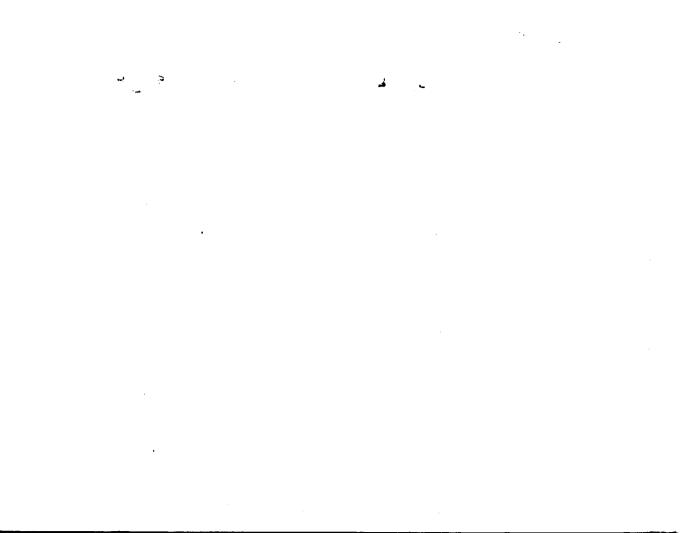
Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

1930 RECORD be made for STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS CERTIFICATE OF . 1836**60** PERMANENT I RETURN must b th stated. 5.214.007-319 Registration District No... State File No... (If born in hospital or institution Prim. Registration District No. 202 Docal Begistrar's No. give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for same of child) Twin Number Date of Legiti-Triplet and in order SEPARATE 1 order of birth birth Chhia/ or other? of birth matel (Month) (Day) (To be answered only in event of plural births) What prophylactic was used to prevent Ophthalmia Neonatorum Number of child of this mother, including present birth Born alive but now dead. Stillborn FATHER MOTHER FIII.I. FULL MAIDEN NAME . UNFADING one child at bin number of ea Residence (Usual place of abode) Residence (Usual place of abode) If nonresident, give place and State If nonresident, give place and State Age at last Birthday. Age at last Bi**nthda**y Color or race (Years) Birthplace Birthplace. (City and State or Country) (City and State or Country) Occupation Occupation .. CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was LStillborn on the date above stated. (Signature) \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth. ż



| . 1! .          | STAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | E OF IDA       | 10                                                  |                                                                |
|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------|----------------------------------------------------------------|
| į               | RECEIVED 855 2 1030 DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                |                                                     | NOT WRITE IN THIS SPACE                                        |
|                 | PLACE OF DEATH BUREAU OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                |                                                     | * 1 () (                                                       |
|                 | D / C CERTIFIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ATE OF         | DEATH State                                         | File No.                                                       |
| Co              | unty of Registration Distric                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                | 57                                                  | 43                                                             |
| Cit             | y of Primary Registrati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | N. 2017                                             | Local Registrar's No. 23                                       |
|                 | . 1/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                |                                                     | ,                                                              |
| 2.              | (No(If death occurred in a hospital or institu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | tion, give its | name instead of street and number                   | )                                                              |
|                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                |                                                     | 6.010                                                          |
| 2.              | FULL NAME DULL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | uce.           | •••••••••••••••••••••••••••••••••••••••             | 7),04                                                          |
|                 | (a) Residence. No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | St.                                                 |                                                                |
| Le              | (Usual place of abode) ength of residence in city or town where death occurred.  yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | mos. ds.       | How long in U. S., if of foreig                     | esident give city or town and State) n birth? yrs. mos. ds.    |
| 3.              | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | MEDICAL CER                                         | TIFICATE OF DEATH                                              |
|                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Widowed        | 16. DATE OF DEATH                                   |                                                                |
| 3.              | 4. COLOR OR RACE 5. Single, Married, or Divorced (write t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | he word)       | Jan Par                                             | /4                                                             |
| 58              | Hernale While                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                | (Month                                              | ) (Day) (Year)                                                 |
| 5a              | . If married, widowed, or divorced HUSBAND of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                | 17. I HEREBY CERTIFY, That I attended deceased from |                                                                |
|                 | (or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                | 7/14                                                | 3 to 7/14 193                                                  |
| 6               | DATE OF BIRTH (month, day and year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                | that I last saw h alive o                           | 9 - 2 - 19 3                                                   |
| 7.              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | than 1 day,    | and that death occurred, on the                     | 1 0                                                            |
| certificate.    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | hrs. or        | _Thes CAUSE OF DEATH* wa                            |                                                                |
| <u>ح</u> ا ي    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | in.            | me low                                              | - Olean                                                        |
| Ē               | OCCUPATION OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                | James En m                                          | within Desarate                                                |
| ಕ ∥             | (a) Trade, profession, or particular kind of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | D 10mm                                              | holdes and                                                     |
| ฮ 🍴             | (b) General nature of industry,<br>business, or establishment in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | Cuthen Fetres                                       | (duration) vra mos                                             |
| on back of cer  | business, or establishment in which employed (or employer)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | 0 10 7                                              | duration)yrs,mos.                                              |
| 8               | (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | CONTRIBUTORY (Secondary)                            |                                                                |
|                 | 11 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | •••                                                 | (duration)yrs,mos.                                             |
| ction 9.        | BIRTHPLACE (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | 18. Where was disease contra                        | cted                                                           |
| nct             | (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                | if not at place of death?                           |                                                                |
| instru          | 10. NAME OF FATHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ce.            | Did an operation precede death                      | Date of                                                        |
|                 | THE PROPERTY AND ADDRESS OF THE PROPERTY OF TH |                | Was there an autopsy?                               |                                                                |
| See             | 11. BIRTHPLACE OF FATHER (ofty or town) (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <i>-</i>       | What test confirmed diagnosis                       |                                                                |
| See inst        | They There                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | -0-            | Signed)                                             | M.                                                             |
| Int.            | 12. MAIDEN NAME OF MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | /// 19-30                                           | (Address)                                                      |
| 2   T           | to promise on Manager and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 7              | State the DIGEAGE CATIG                             | NG DEATH or in deaths from VIOLE                               |
| important<br>PA | 18. BIRTHPLACE OF MOTHER (city or town) (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | CAUSES, state (1) MEANS whether ACCIDENTAL, SUICE   | NG DEATH, or in deaths from VIOLEN AND NATURE OF INJURY, and ( |
|                 | July 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                |                                                     |                                                                |
| is very         | Informant James Chierce                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                | 19. Place of Burial, Cremation                      | n, or Removal Date of Burial                                   |
| <b>&gt;</b>     | (Address Parey Jalake                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | Larry Ola                                           | Tapo July /5"                                                  |
| []              | 9 2 3 (1) 211                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1 3 1/2        | 20. Undertaker                                      | Address                                                        |
| 10              | Filed () 10 W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Registrar      | Havint                                              | amor Hailey                                                    |
| <u> </u>        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                |                                                     |                                                                |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager." "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine. etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

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spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia: Bronchopneumonia ("Pneumonia." unqualified, is indefinite); Tuberculosis of lungs, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bron-chopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Stack," "Ulcomi," "Wood-see," as the stack of the symptom of the symp "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

| _ [                                    | PLACE OF IDAHO                                                                                  |
|----------------------------------------|-------------------------------------------------------------------------------------------------|
| ا قو                                   | DEPARTMENT OF PUBLIC WELFARE                                                                    |
| 돌음                                     | County of BUREAU OF VITAL STATISTICS                                                            |
|                                        | City of CERTIFICATE OF BIRTH                                                                    |
| KECOKD<br>be made fo                   | No. 493- 224:00 F. 6415 CERTIFICATE OF BIRTH D 183667                                           |
| 4 1                                    | Registration District No. State File No.                                                        |
| 23 8                                   | (if born in hope and or institution prim. Registration District No. 2 2 Local Registrat's No. 5 |
| NENT<br>must                           |                                                                                                 |
| \$ 25 B                                | FULL NAME OF CHILD Sullborn Marilyn (1990)                                                      |
| PERMAN<br>RETURN<br>th stated.         | FULL NAME OF CHILITATION (If stillborn, substitute the ford "Stillbirth" for name of child)     |
| E E E                                  | Specof Twin and Number in order Legiti- Date of 2 - 2 4 1930                                    |
| <b>₹</b> E                             | Child or other? of birth mate? birth (Month) (Day) (Year)                                       |
| 252                                    |                                                                                                 |
| 2 2 5 E                                | What prophylactic was used to prevent Ophthalmia Neonatorum?                                    |
|                                        | Number of child of this mother, including present birth (a) Born alive and now living           |
| THIS IS A P SEPARATE RI order of birth | Born slive but now dead Stillborn                                                               |
| A sign                                 | TATHER O O O O O O O O O O O O O O O O O O O                                                    |
| birth<br>each,                         | NAME William Fredrick Tilworthame Jarah of and                                                  |
| · · ·                                  | Residence (Usual place of abode) Taren alda Residence (Usual place of abode)                    |
| UNFADIN<br>ne child at<br>number of    | Residence (Usual place of allowy)                                                               |
| Child<br>nber                          | If nonresident, give place and State                                                            |
| 달라를                                    | Color or race  Age at last Birthony (Years)  Color or race  Age at last Birthony (Years)        |
| I ge C                                 | Birthplace Gille and State on Country)                                                          |
|                                        | City and State or Country)                                                                      |
| WITH<br>than<br>nd th                  | CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*                                                  |
| B e ₹                                  | (Born slive) $2.5$                                                                              |
| LY Inore                               | I hereby certify that I attended the birth of this child, who was Stillborn at M.               |
| E S                                    | on the date above stated. (Signature)                                                           |
|                                        | (Signature)                                                                                     |
| PILA<br>Case                           | *Where there was no attending physician (Physician or midwife)                                  |
|                                        | or midwife, then the father, householder,                                                       |
|                                        | etc., should make this return. A stillborn                                                      |
| WRITE<br>B.—In                         | child is one that neither breathes nor Filed 8-30 1930 Wofen of Wright                          |
| ź                                      | shows other evidence of life after birth.   Filed 19 19 Registrar.                              |
|                                        | . 1                                                                                             |

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| ENT RECORD stated EXACTLY, PHYSICIANS d. Exact statement of OCCUPA- | PLACE OF DEATH County of City | DO NOT WRITE IN THIS SPACE State File No                                                                                                                      |  |  |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| NENT R<br>stated<br>ied. Exa                                        | (Usual place of abode) Length of residence in city or town where death occurred. yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ) yie. mos. ds.                                                                                                                                               |  |  |
| ING<br>PERMANENT<br>should be state                                 | PERSONAL AND STATISTICAL PARTICULARS  SEX  4. COLOB OR RACE 5. Single, Married, Widowed, or Divorced (write the yord)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  (Month)                                                                                                      |  |  |
| BIND<br>IS A<br>AGE<br>prope                                        | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (Month) (Day) (Year)  17. I HEREBY CERTIFY, That I attended deceased from  19                                                                                 |  |  |
| RVED FOR INK—THIS supplied. It may be rificate.                     | 6. DATE OF BIRTH (month, day and year)  7. AGE Years Months Days LESS than 1 day, hrs. or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | and that death occurred, on the date stated above, at 370 m.                                                                                                  |  |  |
| E - 7 F                                                             | 8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (duration) yrs. mos. ds.                                                                                                                                      |  |  |
|                                                                     | (b) General nature of industry, business, or establishment in which employed (or employer)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                               |  |  |
| Amet of                                                             | 9. BIRTHPLACE (city or town) (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (Secondary)  (duration) yrs. mos. ds.  18. Where was disease contracted                                                                                       |  |  |
| rain r                                                              | 10. NAME OF FATHER Fredrick D'Dwort                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | if not at place of death?  Did an operation precede death?  Date of  Was there an autopsy?                                                                    |  |  |
| TE PLAINLY<br>of information<br>OF DEATH i                          | 11. BIRTHDIACE OF FATHER (city or town) (State or Jountry)  12. MAIDEN NAME OF MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What test confirmed diagnosis?  (Signed)  M. D.                                                                                                               |  |  |
| WRITE byery item of i ate CAUSE OF very important.                  | 18. BIRTHPLACE OF MOTHER (city or town) (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |  |  |
| Every state CA is very i                                            | 14. Informant (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 19. Place of Burial, Cremation, or Removal                                                                                                                    |  |  |
| N. B.—<br>should s<br>TION is                                       | 15. Filed 8 - 30, 19.30 P. CT. U. Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 20. Undertaker Address                                                                                                                                        |  |  |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer. Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inantion," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis." etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident: Revolver wound of head-homicide: Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

DIVISION OF VITAL STATISTICS

## DEPARTMENT OF COMMERCE BUREAU OF VITAL STATISTICS

C.K. MACEY SPECIAL AGENT

Boise, Idaho

SEP 22 1930

183667

Mrs. W.F. Dilworth Carey

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT. DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

| 1930 SEX OF Female                      |
|-----------------------------------------|
| CHILD Towns                             |
| ding present birth true                 |
|                                         |
|                                         |
| h Divid Hilworts                        |
| (Full maiden name)  Lucio.  (Residence) |
| ast birthday 35 Paris, I Laho.          |
| (birthplace)                            |
|                                         |

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

Special Agent, Bireau of the Census.

• •

PLACE OF BIRTH STATE OF IDAHO AUG 2 3 1030 DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS. City of ... CERTIFICATE OF BIRTH 183791Registration District No......L. .....State File No..... (If born in hospital or institution give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Number Date of Sex of Legiti-Triplet in order birth Child or other? mate? (To be answered only in event of plural births) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum Number of child of this mother, including present birth...... (a) Born alive and now living..... Born alive but now dead......Stillborn ...... FULL MAIDEN FITT It non-resident, give place and State If non-resident, give place and State, Color or race Color or race Birthplace . (City and State or County) Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician? or midwife, then the father, householder, Physician or midwife etc.. should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Besistation District No. Control of the last of the las Brim leasteration wireles Ho. PULL NAME OF CHULD if allborn, subst late mergere sie teller mi ons River lo dield. when proposition with treed to prevent (phillialinia Monatarent section of the mother, including present birth, and there all and and give trees, wash were full oyll a pint. 447.7 I whole to east total I me would And the second second and the second s Tolor or rate of the wind the state of tolors. opinion and the opinion of L. Strike Bring Destroation ... WHITH BO VALUEYES COM The world thereby or the fattended the birth of this child, with wast little con lights white such our will Selection of the second of the mattering subscript on the last of the last of Allebim 19 nololey dila. tobiosepai reprit deta de telura A stilliore this cole all reliber breathes aver Address Mess other evidence of life after birth

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| ]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                    | DEPARTMENT OF PUBL                                          | IC WELFARE       | DO NOT WRITE IN THIS SPACE                                                                                                 |  |
| z                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | RECEIV TO AUG 23                                                   | 1930 BUREAU OF VITAL STATISTICS                             |                  | 71695                                                                                                                      |  |
| PHYSICIAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                    | COMPANIE OF                                                 |                  | State File No.                                                                                                             |  |
| 25                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | County of Cassia                                                   | CERTIFICATE OF                                              |                  |                                                                                                                            |  |
| ž I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | City of Burley                                                     | Registration District No                                    |                  |                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | City of 1222                                                       | Primary Registration District                               | No               | Local Registrar's No.                                                                                                      |  |
| _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                    |                                                             |                  |                                                                                                                            |  |
| _ <u>`</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (If doubth one                                                     | suppled in a haspital or institution, give                  | its name instead | of street and number.)                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                    | Phillip                                                     |                  | <b>₽</b>                                                                                                                   |  |
| EXACTLY<br>classified.<br>is on back.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2. FULL NAME CONCLE                                                | Musy                                                        |                  |                                                                                                                            |  |
| ∰ 43 °                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (a) Residence. No.                                                 |                                                             | St               | (If nonresident give city or town and State.)                                                                              |  |
| ig d_g                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (Usual place of abode.)  Length of residence in city or town where | death occured. yrs. mos.                                    | ds. How long     | in U. S. if of foreign birth? yrs mos. ds.                                                                                 |  |
| RD.<br>be stated<br>e properly c<br>instructions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                    |                                                             | 1                | MEDICAL CERTIFICATE OF DEATH                                                                                               |  |
| etri st                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | PERSONAL AND STATISTIC                                             |                                                             |                  |                                                                                                                            |  |
| CORD Id be y be ree ins                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 8. SEX COLOR OR RACE                                               | 5. Single, Married, Wildowed, or Diverced (write the word.) | 16. DATE OF      | DEATH 10 0X                                                                                                                |  |
| ECO<br>and<br>ay b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | MA IN                                                              | Dingle                                                      | <u></u>          | (Month) (Day) (Year)                                                                                                       |  |
| RECOMPANDED IN MANDEL SECTION OF THE | 5a. If married, widowed, or divorced                               |                                                             |                  | (                                                                                                                          |  |
| E H H H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | HUSBAND of                                                         |                                                             | 17. LHEREB       | CERTIFY, That I attended decease d from                                                                                    |  |
| S S S S S S S S S S S S S S S S S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (or) WIFE of                                                       |                                                             | Inc.             | 22 1 19 30, to mly 22, 1936                                                                                                |  |
| A BILLANEN A GE THAT DOORTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 6. DATE OF BIRTH (month, day and year)                             | Let 12 1930                                                 | what I last saw  | 14-1011                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7. AGE Years Month                                                 | Days / If LESS than 1 day,                                  |                  | ath occurred, on the date stated above, atm.                                                                               |  |
| PER. plied. ms, s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                    | hrs. or                                                     | and that dea     | TOPACE CAUSING DEATH or in deaths from VIOLENT                                                                             |  |
| E TEES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | all her yarr                                                       | min.                                                        | CAUSES, tat      | ISEASE CAUSING DEATH, or in deaths from VIOLENT is (1) MEANS AND NATURE OF INJURY, and (2) DENTAL, SUICIDAL, or HOMICIDAL. |  |
| S S S S S S S S S S S S S S S S S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 8. OCCUPATION OF DECEASED                                          |                                                             | The CAUSE O      | F DEATH* was as follows:                                                                                                   |  |
| Set in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (a) Trade, profession, or particular kind of work                  |                                                             | Unali            | lies and wound award                                                                                                       |  |
| THIS IS Carefully I in plain                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                    |                                                             | la la            | 1) /1-11-                                                                                                                  |  |
| A E S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (b) General nature of industry,<br>business, or establishment in   |                                                             | June 1           | (lune around) Showfulston                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | which employed (or employer)                                       |                                                             | how !            | Tichling of cont                                                                                                           |  |
| 2 Z Z Z Z Z                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (c) Name of employer                                               | -                                                           |                  |                                                                                                                            |  |
| DEE' E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 9. BIRTHPLACE (city or town) 21                                    | irley ()                                                    |                  | (duration)yrsmosOds.                                                                                                       |  |
| Sho<br>Sho<br>OF<br>t of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (State or country)                                                 | I was.                                                      |                  | DRY                                                                                                                        |  |
| ADINA<br>n sho<br>E OF<br>ent o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 10. NAME OF FATHER                                                 | hillips                                                     | (Secondary       | ds.                                                                                                                        |  |
| em circ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                    |                                                             | 11               | · ·                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 11. BIRTHPLACE OF FATRER (city                                     | or town)                                                    | 18. Where we     | as disease contracted place of death?                                                                                      |  |
| H S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 11. BIRTHPLACE OF FATHER (city (State or Country)                  | ~                                                           | Did an operat    | tion precede death? Date of                                                                                                |  |
| is tar in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                    |                                                             | Was there an     | autopsy?                                                                                                                   |  |
| F B B B                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 12. MAIDEN NAME OF MOTHER                                          | la hayley                                                   | What test co     | onfirmed diagnosis?                                                                                                        |  |
| X, H E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 18. BIRTHPLACE OF MOTHER (city                                     | P town)                                                     | 11               | ) Allan tragur, M. D.                                                                                                      |  |
| PLAINLY<br>very item<br>shoul                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (State or County)                                                  | Cers //                                                     | II               | , 19 (Address) Buly, Elsho                                                                                                 |  |
| ₫ [2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1 (1 )                                                             | 1100                                                        |                  |                                                                                                                            |  |
| PLA<br>Every                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Informant Lack                                                     | ullipso,                                                    | 19. Place of     |                                                                                                                            |  |
| 門门                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (Address) Burley                                                   | Ada                                                         | 1200             | lax da July 22 1921                                                                                                        |  |
| R.F.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 15.                                                                | 5 1HD -A-                                                   | 20 Underte       | Addicess                                                                                                                   |  |
| ĕż                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Filed 20 - 1934                                                    | Registrar.                                                  | 11/10            | > Johnson Turles                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                    |                                                             | /                |                                                                                                                            |  |

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Do not accept a certificate of death signed only by a midwife.

PLACE OF BEGEIVED AUG 2 3 1930 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE HIS IS A PERMANENT RECORD SEPARATE RETURN must be me County of .... BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH (If born in hospital or institution Prim. Registration District No....Local Registrar's No.... give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number Date of Legiti-Sex of Triplet and in order mate? Als birth Child or other? (To be answered only in event of plural births) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead Stillborn FULL MAIDEN NAME ..... Residence (Usual place of abode) It non-resident, give place and State. Color or race...... at last Birthday Birthplace ... Birthplace (City and State or County) (City and State or County) Occupation Occupation (1) CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was \ Stillborn on the date above stated. (Signature) \*Where there was no attending physician WRITE B.—In or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Registrar.

SOFTER TO THE TENTION OF THE PROPERTY OF THE SEC. figuration District No. her a state of institution Print Bergstation District No., C. THE NAME OF CHULD and in order dired to I to be answered with its control limit birthet White prophetic was their to prevent Colthabuta Roundorum? seember of unful of the mother mether mether birth. ...... (a) Bern after and now theny Born sike hut now dead JJIM Perisoner Lead clare of mante if conservation, were chare and Prairie and commenced to it maintendent, eter calere end there the care of the first of the fi Chiral start or dounty decoupation and a PRINTICATE OF ATTEMPTOR PHYSICIAN OR MIDWITE: Lherelly sprift that leatinged the birth of this child, who was stillness All the late share visited. There there was no attending physician Stavelin or milwith. ne addwise, then the father, householder, ett., should make this return. A silliborn Address ... com. cities in and that neither preaction nor shows other estitates of the after birth. Kiled ...

and the second second second second second

| PLACE OF DEATH  County of Cassia City of Burley  City of City  | Local Registrar's No. |  |  |
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| 2. FULL NAME Baby Steward  (a) Residence. No.  Lemeth of relations birth: yrs. mo.  (b) Residence. No.  Lemeth of relations birth: yrs. mo.  DEFINITE STATES BABY Steward  (c) Residence. No.  Lemeth of relations birth: yrs. mo.  DEFINITE STATES BABY Steward  (d) Residence. No.  Lemeth of relations birth: yrs. mo.  DEFINITE STATES BABY Steward  (e) Residence. No.  Lemeth of relations birth: yrs. mo.  DEFINITE STATES BARY (Under the procession of the particular states) birth. yrs. mo.  DEFINITE STATES BARY (Roth)  Sa. H. marriet, widowed, or divorced HUSEAND of (Nonth)  (Roth)  15. DATE OF DEATH  16. DATE OF DEATH  16. DATE OF DEATH  17. HERRBY CERTIFY. That I attended decease of from word of (or) Wife of (or) Wif | 19                    |  |  |

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STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No..... State File No. Prim. Registration District No. 2/19 Local Registrar's No. 186 (If born in hospital or institution give name.) FULL NAME OF CHILD... (If stillborn, substitute the word "Stillbirth" for name of child) Number Date of Legiti-Sex of Triplet in order birth Child ~ or other? mate? (To be answered only in event of plural births) What prophylactic was used to prevent Ophthalmia Neonatorum? MAIDEN NAME Residence (Usual place of abode) MUSICAL A MI It non-resident, give place and State If non-resident, give place and State CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE® Rossothine I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. \*Where there was no attending physician? or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Registration Philipet No. forim Regist, Lion District No. Local Resistration if atthors, and stime the group Stillafith Inc using of childs Number | Num To be assessed caly in event of white Whise prophylactle was used to prevout (spithulosis Negautorom? the state of the s A Stationary of the state of th had you the salls sind Teridona Unique de abore en ab If non-retident, give place and Conv. a come or care of the at last Blithday pro color or rate of the first that the thirthday Distribution .... th cupation CHRIPTIAN ATE OF ATTEMBERG PHYSICIAN DE MINNEY I herody escalify that I attended the bieth of this child, who read Stilliagn det the date above states. (Signature) the place there was no poleculing intralicion i by swingle, then the father, boureholder oredilite A stretes this cetara. A stillbert Marks. child in one that nectors, breather not of us other evidence of the after birth.

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| WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated. |   |   |
| WRI                                                                                                                                                                                                |   |   |
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| City of Wexdeld  No. St.  (If born in hospital or institution give name.)  FULL NAME OF CHILD  Twin  Triplet And \ Number in order                                                                                                                                                              | STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH  Strict No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Child male or other? of birth (To be rose red only in event of phres birth                                                                                                                                                                                                                      | mate? birth 1900 (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| What prophylactic was used to prevent Ophthalmia                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Number of child of this mother, including present birth Born alive but now dead                                                                                                                                                                                                                 | ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Residence (Usual place of abode) Libera dell Idalio                                                                                                                                                                                                                                             | Residence (Usual place of abode) Wendell Jelako                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| It non-resident, give place and State                                                                                                                                                                                                                                                           | If non-resident, give place and State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Birthplace (Years) Occupation (Age at last Birthday (Years)                                                                                                                                                                                                                                     | Birthplace (City and State or County) Occupation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| I hereby certify that I attended the birth of this on the date above stated.  (S  *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. | child, who was Stillborn at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                 | red polici.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

MINES TO THE WILLIAM TO STATE OF THE AREA 的"是外生 Matty in Discover No. The Region or the Bulletin St. Co. . Long Manager St. the Marine with an allered them. beerfi. is order in the court of the co 933345 White come factle was used to make Ophibatella Neonatorum was and a contract the state of the second o un wearing will If men added it is the total and the total and it Court of the Mark the Start In Come THE PARTY OF THE P is a distribution Gengmyation EXPERIENCE OF ATTENDED FOR SHEET OF MEDICALE AVIDE DOWN If the latter the well of this wild, who un sufficient (Memphase) Trends Report maintains bismother militarion of tradition Physician of allewith) in it with the inch STREET, THE POST SOUTH AND REAL PROPERTY. gt son ill bilds L' LE HELTO HWELL

| A-                                                               |                                                                                                                                                   | STATE OF IDA                                    | HQ                                                                                                    |                                                                                                                   |  |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|--|
| <b>₹</b> ₽                                                       | PLACE OF DEATH 1080 ARTMENT OF PUBL.  PLACE OF DEATH BUREAU OF VITAL S                                                                            |                                                 | IC WELFARE DO NOT WRITE IN THIS SPACE                                                                 |                                                                                                                   |  |
| <u>5</u> 5                                                       |                                                                                                                                                   |                                                 | ATISTICS                                                                                              | In the opening of the second                                                                                      |  |
| PHYSICIAN<br>of OCCUPA                                           | and Look                                                                                                                                          | CERTIFICATE OF                                  | <b>DEATH</b> St                                                                                       | tate File No                                                                                                      |  |
| # 4                                                              | County of Strong                                                                                                                                  | Registration District No                        | I                                                                                                     |                                                                                                                   |  |
| <b>.</b> #                                                       | City of Wendell                                                                                                                                   | Primary Registration District                   |                                                                                                       | Local Registrar's No                                                                                              |  |
| ne LY                                                            |                                                                                                                                                   |                                                 |                                                                                                       | 1                                                                                                                 |  |
| ORD<br>ACTL<br>statem                                            | (If death occurre                                                                                                                                 | d in a hospital or institution, give its        | name instead of street and nun                                                                        | nber.)                                                                                                            |  |
| RECORD<br>EXACTLY<br>cact stateme                                | 2. FULL NAME                                                                                                                                      | Paly Iverson                                    | 1                                                                                                     | 2014                                                                                                              |  |
| H e X                                                            | (a) Residence. No                                                                                                                                 |                                                 | St                                                                                                    |                                                                                                                   |  |
| INT<br>ate                                                       | (Usual place of abode) Length of residence in city or town where des                                                                              | th occurred. yrs. mos. ds.                      | (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.    |                                                                                                                   |  |
| DING A PERMANENT should be state erly classified.                | PERSONAL AND STATISTIC                                                                                                                            | AI. PARTICULARS                                 | MEDICAL CERTIFICATE OF DEATH                                                                          |                                                                                                                   |  |
| RMAI<br>ld be<br>lassifi                                         | 3. SEX 4. COLOR OR RACE                                                                                                                           | 5. Single, Married, Widowed,                    | 16. DATE OF DEATH                                                                                     |                                                                                                                   |  |
| ING ING Should rly clas                                          | or Divorced (write the word)                                                                                                                      |                                                 | Q.                                                                                                    | ely 5 1030                                                                                                        |  |
| INC<br>P. Sho Sho                                                | 5a. If married, widowed, or divorced                                                                                                              | Infant                                          | (Mc                                                                                                   | onth) (Day) (Year)                                                                                                |  |
|                                                                  | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                                                      |                                                 | 17. I HEREBY CERTIFY, That I attended deceased from                                                   |                                                                                                                   |  |
| BIN<br>IS<br>AGE<br>prop                                         | (or) WIFE of                                                                                                                                      |                                                 | July 3                                                                                                | 1930, to July 3, 1930.                                                                                            |  |
| FOR 1<br>THIS<br>ed. A                                           | 6. DATE OF BIRTH (month, day and year)                                                                                                            |                                                 | That I last saw h alis                                                                                | n 1930                                                                                                            |  |
| F. T. F. G. S.               | 7. AGE Years Months                                                                                                                               | Days If LESS than 1 day,                        | and that death occurred, on                                                                           | the date stated above, atm.                                                                                       |  |
| SVED FO INK—TH supplied. it may tificate.                        |                                                                                                                                                   | min.                                            | The CAUSE OF DEATH*                                                                                   |                                                                                                                   |  |
|                                                                  | 8. OCCUPATION OF DECEASED                                                                                                                         |                                                 | Francture Deferation Placenta                                                                         |                                                                                                                   |  |
| E to Pa a a                                                      | (a) Trade, profession, or particular kind of work                                                                                                 |                                                 | (duration)yrs,mos,ds.  CONTRIBUTORY (Secondary)(duration)yrsmos,ds.  18. Where was disease contracted |                                                                                                                   |  |
| RGIN RES<br>UNFADING<br>be carefull<br>erms, so the              | (b) General nature of industry.                                                                                                                   |                                                 |                                                                                                       |                                                                                                                   |  |
| GIN INFAI                                                        | business, or establishment in which employed (or employer)  (c) Name of employer  9. BIRTHPLACE (city or town) Wessell Jelaho. (State or country) |                                                 |                                                                                                       |                                                                                                                   |  |
| 2 2 ° E 2                                                        |                                                                                                                                                   |                                                 |                                                                                                       |                                                                                                                   |  |
|                                                                  |                                                                                                                                                   |                                                 |                                                                                                       |                                                                                                                   |  |
| MA<br>NLY, WITH<br>ation should<br>TH in plain<br>instruction of |                                                                                                                                                   |                                                 |                                                                                                       |                                                                                                                   |  |
| n sh W                                                           | 10. NAME OF FATHER                                                                                                                                |                                                 | if not at place of death                                                                              |                                                                                                                   |  |
| LY<br>ion<br>H is                                                | Vernon                                                                                                                                            | C Lucison                                       | Was there an autopsy?                                                                                 | eath? Date of                                                                                                     |  |
| IN<br>nat<br>ATI<br>e ij                                         | 2 11. BIRTHPLACE OF FATHER (city or                                                                                                               | 40000                                           | What test confirmed diagno                                                                            |                                                                                                                   |  |
| PLAINLY<br>aformation<br>DEATH i                                 | (State or Country)                                                                                                                                |                                                 | (Signed)                                                                                              |                                                                                                                   |  |
|                                                                  |                                                                                                                                                   |                                                 |                                                                                                       |                                                                                                                   |  |
| WRITE item of i                                                  | 12. MAIDEN NAME OF MOTHER                                                                                                                         |                                                 |                                                                                                       |                                                                                                                   |  |
| WRI<br>item o<br>AUSE<br>importa                                 | 18. BIRTHPLACE OF MOTHER (city of                                                                                                                 | 18. BIRTHPLACE OF MOTHER (city or town) Medical |                                                                                                       | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) |  |
| it.<br>in                                                        | (State or Country)                                                                                                                                |                                                 | whether ACCIDENTAL, S                                                                                 | UICIDAL, or HOMICIDAL.                                                                                            |  |
| Every state Cais very                                            | 14. Informant De C                                                                                                                                | Liver Down:                                     | 19. Place of Burial, Crems                                                                            | ation, or Removal Date of Burial                                                                                  |  |
| Ever stat                                                        | (Address) 1/1 / 00                                                                                                                                | 1.1.1.                                          |                                                                                                       | 19                                                                                                                |  |
|                                                                  | 15. Landell                                                                                                                                       | 5 8 0                                           | 20. Undertaker                                                                                        | Address                                                                                                           |  |
| B.<br>Foulc                                                      | 16. Filed Sept 3, 19.30                                                                                                                           | Registrar                                       |                                                                                                       |                                                                                                                   |  |
| ZEE                                                              | ļ                                                                                                                                                 | negistrar                                       |                                                                                                       | 1                                                                                                                 |  |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer. Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery: (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

1915

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of ...... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shook," "Williamis," "Wi "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis." etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH No. 912-116.028-152 Registration District No. (If born in hospital or institution Prim. Registration District No... 10.5 ULocal Registrar's No. 15 7 give name.) Tassmussen FULL NAME OF CHILD.. (If stillborn, substitute the word "Stillbirth" for name of shild) Number Twin Date of Legiti-Sex of Triplet √ in order birth Child (To be answered only in event of plural births) (Month) What prophylactic was used to prevent Ophthalmia Neonstorum? Born alive but now dead Stillborn FULL Residence (Usual place of abod If non-resident, give place and State Color or race Occupation ..... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE Born-elive I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DEPARTMENT OF PURISO WELLARE BUREAU OF VITAL STATISTICS" RETREECATE OF BEREIN TOPETON SHE NOTES Registration District No...... Chain in hospital or institution WHEN THE OF CHILD AND SHEET AND THE iff stillborn, substitute the word "Stillbirth" for name of abild) Number: Date of Legid and In order mate? arrive so h (To be suggested and a covered placed birther) Raal prephylacide was used to mever boundaring Vennstorum? more with the day of the design of the second 3311.01d A.H. Wall JA. DEN ~ in which was a second of the s Louis with their their bear place of whether whether if non-resultation gives place and there, advantagement are contracted the CRETIFICACE OF ATTENDING PHYSICIAN OR MIDWIFEN Porzi zlive Thereby certify that I attended the birth of this child, who said atiffboro on the date above stated. \*AVERSO there was no attending physician (Physician or midwiffer or mulyife, then the father, householder, etc. should make this return. A stillborn Address ebild is one that nelther breathes nor shows other evidence of Me see: birth f

STATE OF IDAHO RECEIVED SEP 1 1 1930 PHYSICIAN
of OCCUPA DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No..... County of Registration District No. 30 Local Registrar's No.... Primary Registration District No. 1050 RECORD asmussen Residence. No...... (Usual place of abode)
Length of residence in city or town where death occurred. (If nonresident give city or town and State) How long in U. S., if of foreign birth? YTS. PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH 16. DATE OF DEATH 3. SEX COLOR OR RACE Single, Married, Widowed, or Divorced (write the word) single (Month) 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of 17. I HEREBY CERTIFY, That I attended deceased from 6. DATE OF BIRTH (month, day and year) If LESS than 1 day, 7. AGE Years Months Days and that death occurred, on the date stated above, at... O brs. or The CAUSE OF DEATH was as follows: OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in (duration) \_\_\_\_\_vrs. \_\_\_\_mos. \_\_\_ which employed (or employer) CONTRIBUTORY (c) Name of employer (Secondary) (duration) \_\_\_\_\_yrs. \_\_\_mos. \_ 9. BIRTHPLACE (city or town 18. Where was disease contracted if not at place of death? (State or country) 10. NAME OF FATHER Did an operation precede death? ... Date of..... Was there an autopsy? .. 11. BIRTHPLACE OF FATHER What test confirmed diagnosis? . (State or Country) State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE OF MOTHER (cit (State or Country) 14. Burial Cremation, or Removal Date of Burial Informant (Address) Address

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife. Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Shock" "Ureami," "Washross," at whom a definite "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

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Do not accept a certificate of death signed only by a

midwife.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of A. BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No....State File No... (If born in hospital or institution Prim, Registration District No. 105 Local Registrar's No. 15 give name.) FULL NAME OF CHILDS. (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Date of Legitiand { in order Sex of Triplet birth Child or other? mete? (To be answered only in event of plural births) (Month) What prophylactic was used to prevent Ophthalmia Neonatorin? Number of child of this mother, including present birth...... (a) Born alive and now living..... FULL MAIDEN If non-resident, give place and St It non-resident, give place and ate or County) Occupation \_\_\_\_\_ CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE Born alive I hereby certify that I attended the birth of this child, who was! Stillborn on the date above stated. (Signature) \*Where there was no attending physician? or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DEPARTMENT OF PERIOD WELLIC WELL-KARE BEREAU OF LEVAL STATISTICS OUNTERS OF BIRTH Registration District No. State 1416 No. noiluiliani was lesson wi mach the Propo Registration District No., into Local Registraria No. 2 CHILD AND MEAN THAT things of smar and things were were the tor mane of shifts roderav. Date of section in the section of the sectio Leufel-COLINIA blist's (Tothe answered outs in event of site | births) What productionic was used to prevent Opichalinia Neconstante? Born affire hat now dead ...... - Try I - . . -MAIDEN Residence Useal place of abode! Color or race a second age at last britishes careful warmen. Validately lead to applying a sure at wars to rotally dirilipiage .... nobudonofe CHETTER ATERNISHED PRESENTING TO STATE OF STATE OF Horne saire Lheroby certify that I attended the birth of this child, who was | Sillborn instale oroda stale office. (Signature) ..... "Where there was no attending physicians (Fibrotten or orderetten) or raidwife, then the father, bouseholder, eic. should make this return. A stillborn child is one that notther breathes nor shows other evidence of life after hirth.

| ANS<br>IPA-                                                | STATE OF IDAL                                                                         | 1                                                                                                                                                             |
|------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| A P                                                        | RECEIVED JUL 5 1930 DEPARTMENT OF PUBLIC                                              |                                                                                                                                                               |
| -55                                                        | PLACE OF DEATH BUREAU OF VITAL ST.                                                    | 1 (10/3 1                                                                                                                                                     |
| <u> </u>                                                   | County of Jackman CERTIFICATE OF                                                      |                                                                                                                                                               |
| PHYSIC<br>1 of OCC                                         | County of 19010 Man. Registration District No                                         | 30                                                                                                                                                            |
| = 1                                                        | City of Of Ulunu Primary Registration District                                        | No. 1950 Local Registrar's No                                                                                                                                 |
| L'X,                                                       | II                                                                                    | / <b>  F  </b>                                                                                                                                                |
| ORD<br>ACTLY,<br>statemen                                  | (No                                                                                   | name instead of street and number.)                                                                                                                           |
| RECORD<br>EXACT                                            |                                                                                       |                                                                                                                                                               |
| SE SE                                                      | 2. FULL NAME Sas Evelyn Gordon                                                        |                                                                                                                                                               |
| 75.73                                                      | (a) Residence. No                                                                     | St.                                                                                                                                                           |
| AT ate                                                     |                                                                                       | (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.                                                            |
| NG PERMANENT tould be state r classified.                  |                                                                                       | MEDICAL CERMINICAME OF DEAMY                                                                                                                                  |
| FRMANF<br>uld be s<br>classified                           | PERSONAL AND STATISTICAL PARTICULARS                                                  | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |
| g g g                                                      | 3. SEX 4. COLOR OR RACE 5. Single Married, Widowed, or Divorted (write the word)      | 16. DATE OF DEATH                                                                                                                                             |
| NG<br>PER!<br>hould<br>y cla                               | T. Sunals                                                                             | (Month) (Day) (Year)                                                                                                                                          |
| BINDING IS A PE AGE shou                                   | 5a. If married, widowed, or divorced                                                  |                                                                                                                                                               |
| IS A                                                       | HUSBAND of (or) WIFE of                                                               | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                           |
| A Pr                                                       |                                                                                       | 19, 19, 19, 19, 19, 19, 19, 19, 19, 19, 19, 19, 19                                                                                                            |
| 8 ES                                                       | 6. DATE OF BIRTH (month, day and year)                                                | that I last saw h alive on, 19                                                                                                                                |
| FOR THIS ed.                                               | 7. AGE Years Months Days If LESS than 1 day, hrs, or                                  | and that death occurred, on the date stated above, atm.                                                                                                       |
| ED H<br>K—1<br>pplie<br>may<br>icate.                      | 0 8 0 min.                                                                            | The CAUSE OF DEATHY was as follows:                                                                                                                           |
| N H H H H H H H H H H H H H H H H H H H                    | 8. OCCUPATION OF DECEASED                                                             | Stillborn                                                                                                                                                     |
| ert 7 ER                                                   | (a) Trade, profession, or                                                             |                                                                                                                                                               |
| RESERVED DING INK-efully supple that it most of certifical | particular kind of work                                                               |                                                                                                                                                               |
|                                                            | (b) General nature of industry,<br>business, or establishment in                      |                                                                                                                                                               |
| E S S S                                                    | which employed (or employer)                                                          | CONTRIBUTORY                                                                                                                                                  |
| UNE De ca terms, on back                                   | (c) Name of employer                                                                  | (Secondary)                                                                                                                                                   |
| <b>5</b> m = 1°                                            | Bullillan                                                                             | (duration)yrsmosds.                                                                                                                                           |
| WITH<br>WITH<br>should<br>plain<br>ction                   | 9. BIRTHPLACE (city or town) (State or country)                                       | 18. Where was disease contracted if not at place of death?                                                                                                    |
|                                                            | 10. NAME OF FATHER                                                                    | Did an operation precede death? 23 Date of                                                                                                                    |
| Estrica X                                                  | 10. NAME OF FATHER (LINDS (LANds))                                                    | Was there an autopsy?                                                                                                                                         |
| INE Ratio                                                  | - good of Maria                                                                       | l <b>i</b>                                                                                                                                                    |
| PLAI<br>form<br>DEA                                        | 11. BIRTHPLACE OF FATHER (city or town) (State or Country)  12. MAIDEN NAME OF MOTHER | What test confirmed diagnosis?                                                                                                                                |
|                                                            | Jano Jano                                                                             | (Signed) , M. D. (Address Perus Latin Ida                                                                                                                     |
| TE<br>OF                                                   | 12. MAIDEN NAME OF MOTHER ()                                                          | G (Address)                                                                                                                                                   |
|                                                            | Illa Haris                                                                            | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT                                                                                                   |
| WRI<br>item o<br>AUSE<br>import                            | 18. BIRTHPLACE OF MOTHER (city property)                                              | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| ¥.:                                                        | (State or Country)                                                                    |                                                                                                                                                               |
| - P                                                        | 14. Informant & Warland                                                               | 19. Place of Burial, Cremation, or Removal Date of Burial                                                                                                     |
| Ever<br>state                                              | (Address) Bot Al Colon and Address                                                    | But bemley Eddlen 6/8 1928                                                                                                                                    |
|                                                            | Musicum and                                                                           | '20. Undertaker Address                                                                                                                                       |
| M TO                                                       | 15. Filed 6/16, 1930 H. Y. Sturges M. D.                                              | Was at Tunes of Horne - hope to the Walne Dad !                                                                                                               |
|                                                            | / Registrar                                                                           | MAKEN I MAKEN HAT CAN THE MAKEN                                                                                                                               |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer. Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"): Lobar pneumonia: Bronchopneumonia ("Pneumonia." unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

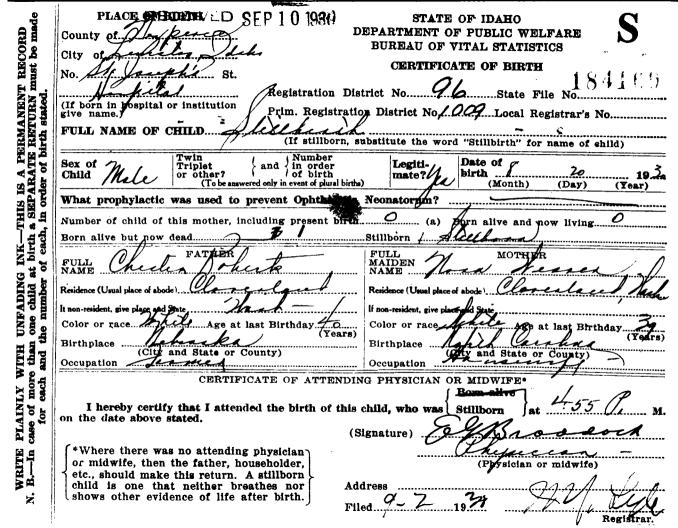
DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.



County of Land if horn in pospital or institution FULL YAME OF CHILD.... Phorf (Tabe newer duc) m created title) or other? What prophylactic was used to prevent (authat als Neonaturant) Annalog of child of this mother confidence presont burdi... Rorn clive but now dead ........ Residence (Usual stars at their sections) ton to the plant was the plant to the plant Come or gain A by Left, save at less thirdway M L. L. Color or race, L. L. L. See at lang the growth Wife and Stale of Corners Occupation See See CERTIFICATION ATTENDING PHYSICIAN OR MIDWIFLS Riereby certify that I are adol the birth of this child, who, was stilliorn fut on the date above stated. f "Energ there was no attending physician or midwife, then the father, householder, sett, should make this return. A stillborn child to one that nelther breather nor allows other evidence of life after birth.

ATE OF IDARO DEPARTMENT OF PUBLIC WELFARE BUILDAN OF VITAL STATISTICS

Think to each not "diribility" brow say and its dan draditive if Legitt. Date of

State Pile N.

If desirables, sire place and trans-

(Physician or midwite)

configuration of the state of t

: Orthonorus II

bird 18

CERTIFICATE OF BURTH

Registration Betrief No. . . . . . . . .

Frien. Register tina District No. 1. 2. 1. ocal Toyl trees No.

| S.                                                             | l       | RECEIVED SEF 6 1930 STATE OF IDAK                                              | 10                                                                                                                                                            |  |  |
|----------------------------------------------------------------|---------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| PHYSICIAN<br>of OCCUPA                                         |         | DEPARTMENT OF PUBLIC                                                           | C WELFARE DO NOT WRITE IN THIS SPACE                                                                                                                          |  |  |
| 55                                                             |         | PLACE OF DEATH BUREAU OF VITAL ST                                              | ATISTICS                                                                                                                                                      |  |  |
| <u> </u>                                                       |         | CERTIFICATE OF                                                                 | DEATH State File No.                                                                                                                                          |  |  |
| E                                                              | Co      | ounty of Lezperce Registration District No                                     |                                                                                                                                                               |  |  |
| #                                                              | Ci      | to at T.Awistan                                                                | 1 Local Pagistron's No.                                                                                                                                       |  |  |
| Y,                                                             |         | Primary Registration District                                                  | · · · · · · · · · · · · · · · · · · ·                                                                                                                         |  |  |
| ORD<br>ACTL<br>statem                                          |         | (No                                                                            | 1 Hospi/Gal                                                                                                                                                   |  |  |
| AC<br>AC<br>sta                                                |         |                                                                                | Marie Instead of Street and number.)                                                                                                                          |  |  |
| ( ) Mal                                                        | 2.      | FULL NAME George Roberts                                                       |                                                                                                                                                               |  |  |
| F − ×                                                          |         | (a) Residence. No.                                                             | St.                                                                                                                                                           |  |  |
| ate I                                                          | T.      | (Usual place of abode)                                                         | (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.                                                            |  |  |
| E targ                                                         |         |                                                                                |                                                                                                                                                               |  |  |
| NG<br>PERMANENT<br>hould be state<br>y classified. E           |         | PERSONAL AND STATISTICAL PARTICULARS                                           | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |  |  |
| RA<br>Pass                                                     | 8.      | SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word) | 16. DATE OF DEATH                                                                                                                                             |  |  |
| ING<br>PERI<br>should                                          | ļ       | Male White                                                                     | august 20 1930                                                                                                                                                |  |  |
| Z ~ Z                                                          | 58      | s. If married, widowed, or divorced                                            | (Month) (Day) (Year)                                                                                                                                          |  |  |
| BINI<br>IS A<br>AGE<br>prope                                   |         | HUSBAND of<br>(or) WIFE of                                                     | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                           |  |  |
| B I S I                                                        |         |                                                                                | aug 10, 19 30, to aug 10, 19 10                                                                                                                               |  |  |
| FOR THIS ed. A                                                 |         | DATE OF BIRTH (month, day and year) Aug 20, 1930                               | that I last saw h alive on                                                                                                                                    |  |  |
| E E E E                                                        | 7.      | AGE Years Months Days If LESS than 1 day,                                      | and that death occurred, on the date stated above, at 4.55 P. m.                                                                                              |  |  |
| VED FOUNTAINSUPPLIES IN MAY IT MAY HISTORY                     |         | Stillborn hrs. or min.                                                         | The CAUSE OF DEATH* was as follows:                                                                                                                           |  |  |
| RESERVED FOR INK—Thefully supplied that it may of certificate. | 8.      | OCCUPATION OF DECEASED                                                         |                                                                                                                                                               |  |  |
|                                                                |         | (a) Trade, profession, or<br>particular kind of work                           | Still Born Premature                                                                                                                                          |  |  |
| RGIN RESE UNFADING be carefully erms, so that                  |         |                                                                                | geewhy                                                                                                                                                        |  |  |
|                                                                |         | (b) General nature of industry,<br>business, or establishment in               | (duration) yrs. 5 mos. ds.                                                                                                                                    |  |  |
| ARGIN<br>UNFA<br>be car<br>terms,                              | 1       | which employed (or employer)                                                   | CONTRIBUTORY                                                                                                                                                  |  |  |
| ARC<br>Uly<br>teri                                             | .       | (c) Name of employer                                                           | (Secondary)                                                                                                                                                   |  |  |
|                                                                |         |                                                                                | (duration) yrs. mos. ds.                                                                                                                                      |  |  |
| MAWITH Should plain ction of                                   | 9.      | BIRTHPLACE (city or town) Lewiston, Ida.                                       | 18. Where was disease contracted if not at place of death?                                                                                                    |  |  |
| VLY, WITJ<br>tion shoul<br>H in plair<br>instruction           |         | 10. NAME OF FATHER                                                             | Did an operation precede death?                                                                                                                               |  |  |
| LY<br>Hijor<br>RSt                                             |         | 10. NAME OF FATHER C E Roberts                                                 | Was there an autopsy?                                                                                                                                         |  |  |
| PLAINLY<br>nformation<br>DEATH i                               | 20      | 11. BIRTHPLACE OF FATHER (city or town)                                        | 3 - 6 - 6                                                                                                                                                     |  |  |
| 7 E 3 8                                                        | IN      | (State or Country) Springfield Nebr                                            | What test confirmed diagnosis?                                                                                                                                |  |  |
|                                                                | PARENTS |                                                                                |                                                                                                                                                               |  |  |
|                                                                | PA      | 12. MAIDEN NAME OF MOTHER NOTA WORVER                                          | (Address)                                                                                                                                                     |  |  |
| WRITE<br>item of i<br>AUSE OF                                  |         | 18. BIRTHPLACE OF MOTHER (city or town)                                        | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT                                                                                                   |  |  |
| it is a second                                                 |         | (State or Country) North Carolina                                              | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |  |  |
| >0 N                                                           | 14      | . C E Roberts (Father)                                                         |                                                                                                                                                               |  |  |
| -Every<br>state (                                              | 19      | Informant                                                                      |                                                                                                                                                               |  |  |
| E 35 8                                                         |         | (Address) Cloverland, Wash                                                     | Clarkston, Wash 8/21/30 19                                                                                                                                    |  |  |
| A P Z                                                          | 15      | 1. 9-1- 38 XXVI WIN                                                            | 20. Undertaker H.R. Merchant Cl. R. St. On 182                                                                                                                |  |  |
| 19.4.<br>10.                                                   |         | Filed Registrar                                                                | n.R. Merchant Clark ston Wn                                                                                                                                   |  |  |

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cide. The nature of the injury, as fractured skull, and con-

sequences (e. g. sepsis, tetanus) may be stated under the

Do not accept a certificate of death signed only by a

midwife.

head of "Contributory."

| County of SEP 5 SID DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS City of CERTIFICATE OF BIRTH  No. St. Registration District No. State File No. S |                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| give name.)  FULL NAME OF CHILD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 192             |
| Child Child or other?  (To be answered only in event of plural births)  What prophylactic was used to prevent Ophthalmia Neonatorum?  Number of child of this mother, including present birth  Born alive but now dead  FATHER  FULL  NAME  Residence (Usual place of abode)  FATHER  Residence (Usual place of abode)  FATHER  FULL  NAME  Residence (Usual place of abode)  Residence (Usual place of abode)  FATHER  FULL  NAME  Residence (Usual place of abode)  Residence (Usual place of abode)  FATHER  FULL  NAME  Residence (Usual place of abode)  Residence (Usual place of abode)  FATHER  FULL  NAME  Color or race  Age at last Birthday  Birthplace  Birthplace  Birthplace                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                 |
| Child Child or other?  (To be answered only in event of plural births)  What prophylactic was used to prevent Ophthalmia Neonatorum?  Number of child of this mother, including present birth  Born alive but now dead  FATHER  FULL  NAME  Residence (Usual place of abode)  FATHER  Residence (Usual place of abode)  FATHER  FULL  NAME  Residence (Usual place of abode)  Residence (Usual place of abode)  FATHER  FULL  NAME  Residence (Usual place of abode)  Residence (Usual place of abode)  FATHER  FULL  NAME  Residence (Usual place of abode)  Residence (Usual place of abode)  FATHER  FULL  NAME  Color or race  Age at last Birthday  Birthplace  Birthplace  Birthplace                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                 |
| What prophylactic was used to prevent Ophthalmia Neonatorum?  Number of child of this mother, including present birth  Born alive but now dead  Stillborn  FATHER  FULL  NAME  Residence (Usual place of abode)  Residence (Usual place of abode)  Residence (Usual place and State  Color or race  Age at just Birthday  Rirthplace  Birthplace  Birthplace  What prophylactic was used to prevent Ophthalmia Neonatorum?  (a) Born alive and now living  FULL  MAIDEN  MOTHER  MAIDEN  MAIDEN  MAIDEN  MAIDEN  MAIDEN  MAIDEN  NAME  Color or race  Age at just Birthday  Birthplace  Birthplace  Birthplace                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | . 195<br>(Year) |
| FULL NAME Stellers State  Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                 |
| FULL NAME Stellers Mother Maintenance (Usual place of abode)  Residence (Usual place of abode)  Birthplace  Right place  |                 |
| Residence (Usual place of abode)  If nonresident, give place and State  Color or race  Righthplace  Righthpla |                 |
| Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ele             |
| If nonresident, give place and State  Color or race  Age at last Birthday  Greats  Birthplace  (City and State or Country)  If nonresident, give place and State  Color or race  Color or race  (City and State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 7_              |
| Color or race Age at last Birthday  (Years)  Birthplace (Oldy and Mate or Country)  Color or race Age at last Birthday  Birthplace (Clay and Mate or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                 |
| Birthplace (City and State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (Years)         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |
| Occupation 7 agricult Occupation Musikut 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                 |
| Occupation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                 |
| I hereby certify that I attended the birth of this child, who was \ Stillborn \ at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | М.              |
| on the date above stated. (Signature)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | _               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | •••••••••••     |
| - Fl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                 |
| etc., should make this return. A stillborn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                 |
| child is one that neither breathes nor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ~~              |
| I SHOWS OTHER EVIDENCE OF THE ALVER DITUIL   LINGUINGS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ristrar.        |

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| TATE OF IDA                                                                            | HO                                                                                                                                                             |
|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SEC SEP 5 DEPARTMENT OF PUBLI                                                          | 1 20 1101 111112 111 11110 111101                                                                                                                              |
| - PLACE OF DEATH BUREAU OF VITAL ST                                                    |                                                                                                                                                                |
| County of Oneida CERTIFICATE OF                                                        | · //.                                                                                                                                                          |
| Registration District No                                                               |                                                                                                                                                                |
| City of Primary Registration District                                                  | No. 2009                                                                                                                                                       |
| (No.                                                                                   | )                                                                                                                                                              |
| (If death occurred in a hospital or institution, give its                              | name instead of street and number.)                                                                                                                            |
| 2. FULL NAME Sell /Jonn 1 70                                                           | rand offill                                                                                                                                                    |
| (a) Residence. No                                                                      | St                                                                                                                                                             |
| (Usual place of abode)                                                                 | (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.                                                             |
| Length of residence in city or town where death occurred. yrs. mos. ds.                | How long in C. S., if of locking bladt. Yes, mos. Qs.                                                                                                          |
| PERSONAL AND STATISTICAL PARTICULARS                                                   | MEDICAL CERTIFICATE OF DEATH                                                                                                                                   |
| 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)      | 16. DATE OF DEATH                                                                                                                                              |
| male white wird (write the word)                                                       | <u></u>                                                                                                                                                        |
| 5a. If married, widowed, or divorced                                                   | (Month) (Day) (Year)                                                                                                                                           |
| HUSBAND of<br>(or) WIFE of                                                             | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                            |
|                                                                                        | 19 to 19 19                                                                                                                                                    |
| 6. DATE OF BIRTH (month, day and year) Ly 2. 1930                                      | that I last saw II                                                                                                                                             |
| 7. AGE Years Months Days If LESS than 1 day,                                           | and that death occurred, on the date stated above, at Ua                                                                                                       |
| Still Bonn min.                                                                        | The CAUSE OF MEATH was as follows:                                                                                                                             |
| 8. OCCUPATION OF DECEASED                                                              | still som, flord over                                                                                                                                          |
| <b>/</b> /                                                                             | laftering trice around                                                                                                                                         |
| (a) Trade, profession, or particular kind of work                                      | neck.                                                                                                                                                          |
| (b) General nature of industry,                                                        | (duration) yrs, mos,                                                                                                                                           |
| business, or establishment in which employed (or employer)                             |                                                                                                                                                                |
| (c) Name of employer                                                                   | CONTRIBUTORY (Secondary)                                                                                                                                       |
| Brale of                                                                               | (duration)yrsmos.                                                                                                                                              |
| 9. BIRTHPLACE (city or town)                                                           | 18. Where was disease contracted                                                                                                                               |
| (State or country)                                                                     | if not at place of death?                                                                                                                                      |
| 10. NAME OF FATHER                                                                     | Did an operation precede death?                                                                                                                                |
| 1 / waster,                                                                            | Was there an autopsy?                                                                                                                                          |
| 11. BIRTHPLACE OF FATHER (city or town)                                                | What test confirmed diagnosis                                                                                                                                  |
| (State or Country) Mansk Jalles Halso                                                  | (Signed), M.                                                                                                                                                   |
| 11. BIRTHPLACE OF FATHER (city or town) (State or Country)  12. MAIDEN NAME OF MOTHERM | Might 1930 (Address) malad X OL                                                                                                                                |
| 1/my ///weals                                                                          | A TOTAL OF GALVANIA PRANTY A TANK                                                                                                                              |
| 18. BIRTHPLACE OF MOTHER (city of Down)                                                | *State the DISEASE CAUSING DEATH, or in deaths from VIOLE:<br>CAUSES, state (1) MEANS AND NATURE OF INJURY, and<br>whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| (State or County)                                                                      | whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                    |
| 14. July 14. 1. 14. 14. 14. 14. 14. 14. 14. 14.                                        | 19. Place of Burial, Cremation, or Removal Date of Burial                                                                                                      |
| Informant Office Code                                                                  | Maled Oda Aug. 2. 19                                                                                                                                           |
| (Address)                                                                              | 20. Undertaker Address                                                                                                                                         |
| 15. Filed 8/5/ , 1950 AMI/am                                                           | a Som Pense Malasch                                                                                                                                            |
| Registrar                                                                              | W my ferman walled                                                                                                                                             |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine. etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework. or At home, and children, not gainfully employed, as Atschool or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia: Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs. meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of ...... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inantion," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF

INJURY and qualify as ACCIDENTAL, SUICIDAL, or

HOMICIDAL, or as probably such, if impossible to de-

termine definitely. Examples: Accidental drowning;

struck by railway train-accident; Revolver wound of

head-homicide; Poisoned by carbolic acid-probably sui-

cide. The nature of the injury, as fractured skull, and con-

sequences (e. g. sepsis, tetanus) may be stated under the

spinal fever (the only definite synonym is "Epidemic

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

head of "Contributory."

| -                                                              | W. V. W. V.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| rde                                                            | PLACE DE DIRTH OF IDAHO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| RD<br>mad                                                      | County of Payelle SEP 15 1980 DEPARTMENT OF PUBLIC WELFARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 28                                                             | City of New Plymouth BUREAU OF VITAL STATISTICS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| REC                                                            | No. St. CERTIFICATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| NE                                                             | Registration District No. State File No. State File No. (If born in hospital or institution                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                | give name.) Prim. Registration District No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| PER                                                            | FULL NAME OF CHILD Sugaret Daruse (Stillborn)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| PERMANENT RECORD<br>TE RETURN must be ma<br>I birth stated.    | (If stillborn, substitute the word "Stillbirth" for name of shild)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| TE E                                                           | Sex of Twin Triplet or other?  Child Wale or other?  Number in order of birth  Legitibirth  Date of the 30  193.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| RA                                                             | Child Male or other? of birth (To be answered only in event of plural births) (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| HS IS A PERMANEN<br>SEPARATE REFURN<br>n order of birth stated | What prophylactic was used to prevent Ophthalmia Neonatorum?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| SEF                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| E 6 -                                                          | Number of child of this mother, including present birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 역성                                                             | Born alive but now dead                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| INK-<br>birth<br>f each                                        | FULL Blench McCleeland Daring MAIDEN Bertha Weles                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| - <b></b> i                                                    | NAME Sleve McClelland Daring NAME Dertha Weles                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| ADING<br>child a<br>umber                                      | Residence (Usual place of abode Mora Plymanich, Sla Residence (Usual place of abode with husband                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                | It non-resident, give place and State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ONE<br>one<br>ie n                                             | Color or race. Age at last Birthday 43 Color or race. Age at last Birthday 40                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                | Birthplace Zabr (Years) Birthplace Zabr (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| than<br>ind t                                                  | (City and State or County) Occupation Tarteller Occupation Occupat |
| 8 5                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| LY W<br>more<br>each a                                         | CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 3 8 8                                                          | Romalize.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| o o                                                            | I hereby certify that I attended the birth of this child, who was Stillborn at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Case of for                                                    | (Signature) T- Dryslale Ma)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 86                                                             | *Where there was no attending physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 37                                                             | or midwife, then the father, householder, (Physician or midwife)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| B. B.                                                          | etc., should make this return. A stillborn child is one that neither breathes nor Address Nr. Peymouth Ha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| z                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| F4                                                             | Filed FPL 1930 W J. W. W. L.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                | V / Registrar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

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cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidmic cerebrospinal meningitis"); Diptheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia"): Lobar Pneumonia: Bronchopneumonia ("pneumonia," unqualified, is indefite): Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of ...... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms: Measles: Whooping Cough: Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia." "Anaemia" (merely symptomatic) "Atrophy." "Collapse." "Coma." "Convulsions." "Debility." ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure." "Hemorrhage." "Inanition." "Marasmus." "O'd Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide: Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

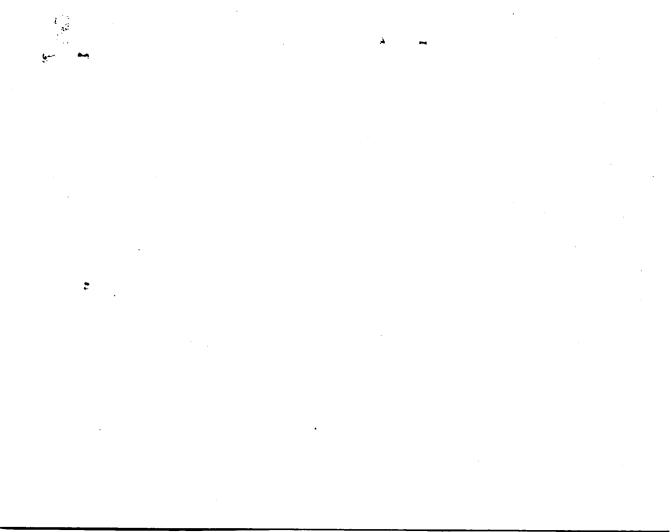
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Do not accept a certificate of death signed only by a midwife.



| NS-A-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | RECEIVED SEP 1 0 1930 STATE OF IDA                                                | HO                                                                                                                                                            |  |  |
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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | PLACE OF DEATH BUREAU OF VITAL ST                                                 | ATISTICS                                                                                                                                                      |  |  |
| XST<br>OC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CERTIFICATE OF                                                                    | DEATH State File No                                                                                                                                           |  |  |
| , PHYSTCIA]<br>nt of OCCUP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | City ofAmerican Falls, Registration District No                                   | No 9/1/2                                                                                                                                                      |  |  |
| LY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ! D. 41 HOST                                                                      | )T.A.I                                                                                                                                                        |  |  |
| ORD<br>ACTL<br>statem                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (If death occurred in a hospital or institution, give its                         | name instead of street and number.)                                                                                                                           |  |  |
| RECORD<br>EXACT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2. FULL NAME Genela O'Harra                                                       | name (Boby Ottaria)                                                                                                                                           |  |  |
| NG<br>PERMANENT RECORD<br>hould be stated EXACTLY,<br>y classified. Exact statemer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (a) Residence. No                                                                 | St. (If nonresident give city or town and State)                                                                                                              |  |  |
| INE<br>e si<br>fied                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | PERSONAL AND STATISTICAL PARTICULARS                                              | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |  |  |
| 3<br>ERMAI<br>uld be<br>classifi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word) | 16. DATE OF DEATH                                                                                                                                             |  |  |
| ING<br>PERI<br>Should                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Male White Single                                                                 | Aug 12th 19 30 (Monta) (Day) (Year)                                                                                                                           |  |  |
| P. S. I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                      | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                           |  |  |
| BIN<br>IS AGE<br>prope                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                   | , 19, to, 19                                                                                                                                                  |  |  |
| E IS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 6. DATE OF BIRTH (month, day and year) Aug 12th 1930                              | that I last saw h alive on, 19                                                                                                                                |  |  |
| CTE<br>TTE<br>oplied<br>may<br>cate.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 7. AGE Years Months Days If LESS than 1 day, O O O                                | and that death occurred, on the date stated above, atm.                                                                                                       |  |  |
| RVED FC INK—TH supplied. t it may                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | January MIIIIs                                                                    | The CAUSE OF DEATH* was as follows:                                                                                                                           |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 8. OCCUPATION OF DECEASED                                                         |                                                                                                                                                               |  |  |
| RGIN RESE<br>UNFADING<br>be carefully<br>erms, so that                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (a) Trade, profession, or particular kind of work                                 | 1 de Los frances                                                                                                                                              |  |  |
| RESTADING CAREFUL S, so the content of the content  | (b) General nature of industry,<br>business, or establishment in                  | (duration) yrs. (mos.                                                                                                                                         |  |  |
| ARGIN I<br>UNFAI<br>be car<br>terms, s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | which employed (or employer)  (c) Name of employer                                | CONTRIBUTORY (Secondary)                                                                                                                                      |  |  |
| <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (0) grant ye dagayar                                                              | (duration)yrsmosds.                                                                                                                                           |  |  |
| MANLY, WITH tion should the in plain instruction of the instruction of | 9. BIRTHPLACE (city or town) American Falls, Idaho (State or country)             | 18. Where was disease contracted if not at place of death?                                                                                                    |  |  |
| = =                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 10. NAME OF FATHER                                                                | Did an operation precede death? Date of.                                                                                                                      |  |  |
| PLAINLY<br>nformation<br>DEATH i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | J.T. O'Harra                                                                      | Was there an autopsy?                                                                                                                                         |  |  |
| PLAINLY<br>nformation<br>DEATH<br>See inst                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 22 11. BIRTHPLACE OF FATHER (city or town) (State or Country)                     | What test confirmed diagnosis?                                                                                                                                |  |  |
| T SEC.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (State or Country)  Ore  12. MAIDEN NAME OF MOTHER  14. C. Patengon               | (Signed) , M. D. Aug 12th 1930 (Address) American Falls                                                                                                       |  |  |
| WRITE<br>m of i<br>SE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 12. MAIDEN NAME OF MOTHER Hilds C. Peterson                                       | AUS 12 CII , 1950 (Address) Auto-12 CII Palls                                                                                                                 |  |  |
| WRITE 1<br>y item of in<br>CAUSE OF<br>y important.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 18. BIRTHPLACE OF MOTHER (city or town) (State or Country)                        | *State the DISEASE CAUSING DEATH, of in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |  |  |
| CA:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   |                                                                                                                                                               |  |  |
| Every state C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 14. Informant J. J. O'Nanc                                                        | 19. Place of Burial, Cremation, or Removal Date of Burial                                                                                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (Address) Roy, Idaho                                                              | Rockland, Idaho 8/12/30 19                                                                                                                                    |  |  |
| N. B.<br>should<br>FION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 15. Filed aya, 2, 1924 Greenen Math                                               | American Falls                                                                                                                                                |  |  |
| ziği                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Registrar                                                                         | Ida Ida                                                                                                                                                       |  |  |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.: Bronchopneumonia (secondary), 10 ds. Never report mere "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Shack" "Urasmia" "Wookrops," etc., "here of the college." "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

STATE OF IDAHO 1020 DEPARTMENT OF PUBLIC WELFARE RECORD BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No...7.7... State File No. SEPARATE RETURN (If born in hospital or institution Prim. Registration District No. 2176 Local Registrar's No... give name.) FULL NAME OF CHILD... (If stillborn, substitute the word "Stillbirth" for name of shild) Number Date of Legiti-Sex of and in order Triplet birth ..... mate? Child or other? (To be answered only in event of plural births) (Month) / (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? FULL MAIDEN NAME ..... Residence (Usual place of abode) If non-resident, give place and State It non-resident, give place and State Color or race \_\_\_\_\_\_Age at last Birthday 3 Color or race...........Age at last Birthday (Years) Birthplace ..... Birthplace ...... (City and State or County) (City and State or County) Occupation ..... Occupation ...... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician? or midwife, then the father, householder. (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Registrar.

CERTIFICATE OF BIRTH P. In Reserve to District No. " า เกรียนสมาคริสาที่ การอเม HELD NAME OF CHILD these to superitude the word 'strickers' or came of chaift To otal - itimes T .fraid mate? calcini) (Day) (Year) What prophylactic was used to prevent Ophthalmia Yeonaterum? Residence | Usus place of alade El the acceptant, give the each time. it were went, nive affine and diale tidor or rave with a mandre at hist Birthday .... telon on pace of the man ... Age as but Pirthian Landing (ED.4Y) (4:56Z4 (vienels in etael ban bittel With and Store or Concini CERROLPECATE OF ATTENDING PHYSICIAN ON MIDWIFES. f-avila minit I hearly registr that I attended the birth of this child, and was building a on the flate above stated. (Stantiffe) emploised there was no attending physician

Where there was no attending physician or nidwife, then the father, householder, etc., should make this return. A stillborn whild it one that neither breathes nor above other evidence of life after birth.

| ENT RECORD stated EXACTLY, PHYSICIANS d. Exact statement of OCCUPA-                    | PLACE OF DEATH  County of City |                                              |                           |                                       | C WELFARE ATISTICS DEATH ~  No. 2 / 76  name instead of street and | State File No                                                | ar's No                                                   |
|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|---------------------------|---------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------|
| ENT Rated 1. Exa                                                                       | (a) Residence<br>(Usual place of<br>Length of residence in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | of abode)                                    |                           | yrs. mos. ds.                         | How long in U. S., if                                              | (If nonresident give city of foreign birth?                  | or town and State) yrs. mos. ds.                          |
| Fig. 7                                                                                 | PERSO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | NAL AND STATISTI                             | CAL PARTICUL              | ARS                                   | MEDIC                                                              | AL CERTIFICATE OF                                            | DEATH                                                     |
| ING<br>PERMANENT<br>should be stated<br>rly classified.                                | 8. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. COLOR OR RACE                             | 5. Single,<br>or Divorced | Married, Widowed,<br>(write the word) | 16. DATE OF DEAT                                                   | <u> </u>                                                     | 1930                                                      |
| Na de de                                                                               | 5a If married widowed, or divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                              |                           | (Month) (Day) (Year)                  |                                                                    |                                                              |                                                           |
| BINDING IS A PE AGE shou properly o                                                    | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                              |                           |                                       | 17. I HEREBY CERTIFY, That I attended deceased from                |                                                              |                                                           |
| BIN<br>S IS<br>AGI<br>Proj                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              | 8/7/                      | 30                                    |                                                                    | •                                                            | , 19                                                      |
| FOR THIS ed. 1                                                                         | 6. DATE OF BIRTH (month, day and year) 7. AGE Years Months Days If LESS than 1 day,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                              |                           |                                       | •                                                                  | •                                                            |                                                           |
| _   i= #+>                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              |                           | hrs. or                               | and that death occurred The CAUSE OF DEA                           | •                                                            | ve, atm.                                                  |
| RESERVED FO<br>DING INK—TH<br>efully supplied.<br>so that it may be<br>of certificate. | 8. OCCUPATION OF  (a) Trade, profess particular kind of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                              |                           | min.                                  | after com                                                          | man of conting head                                          | breed can)                                                |
| GIN<br>NFA<br>e car<br>rms, r                                                          | (b) General natur<br>business, or establ<br>which employed (c)<br>(c) Name of em                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | e of industry,<br>ishment in<br>or employer) | -                         |                                       | CONTRIBUTORY (Secondary)                                           | More Brief                                                   | yrsds.                                                    |
|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2.7                                          | n. R.                     | 26. 25. 20.                           |                                                                    | (duration)                                                   | yrsds.                                                    |
| WITH<br>WITH<br>should<br>plain<br>ction                                               | 9. BIRTHPLACE (city or town) (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              |                           |                                       | 18. Where was disease contracted if not at place of death?         |                                                              |                                                           |
|                                                                                        | 10. NAME OF F.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ather Thro.                                  | N. Cher                   | ay .                                  | _                                                                  | ede death? Dat                                               | e of                                                      |
| PLAINLY<br>nformation<br>DEATH See inst                                                | 11. BIRTHPLACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | E OF FATHER (city of try)                    | r town)                   |                                       | What test confirmed di                                             | iagnosis?                                                    | Tedus M. D.                                               |
| WRITE P<br>m of inf<br>ISE OF I<br>portant.                                            | (State or Cour                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ME OF MOTHER                                 | uea Ha                    | teh                                   | 8/8 , 19                                                           | 30 (Address)                                                 | typo Isa                                                  |
| 15 D E                                                                                 | 13. BIRTHPLACE<br>(State or Cour                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | E OF MOTHER (city                            | or town)                  |                                       | *State the DISEASE<br>CAUSES, state (1) I<br>whether ACCIDENTAL    | CAUSING DEATH, or<br>MEANS AND NATURE<br>L, SUICIDAL, or HOM | in deaths from VIOLENT<br>E OF INJURY, and (2)<br>ICIDAL. |
| Every state CA                                                                         | 14. Informant That                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | S. W. Ther                                   | Maria                     |                                       | 19. Place of Burial, C                                             |                                                              | Date of Burial 8 - 8 - 19 30                              |
| N. B.—<br>should s<br>FION is                                                          | 15. Filed 9-9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | -, 19 30 f                                   | Martha                    | Marker<br>Registrar                   | 20. Undertaker                                                     |                                                              | Address                                                   |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine. etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia: Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs. Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere chopheumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite discount care has accordingly to the control of the con disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS-Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated

Registrars should be careful to see that the medical

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Do not accept a certificate of death signed only by a midwife.

RETURN must be made STATE OF IDAHO PERMANENT RECORD DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH No. Registration District No............State File No. (If born in hospital or institution give name.) Prim. Registration District No. 2. .... Local Registrar's No. FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of shild) 70 Sex of Number Child Temele Triplet Date of in order Legitior other? mate? (To be answered only in event of plural births) What prophylactic was used to prevent Ophthalmia Neonasorum? (Year) Number of child of this mother, including present birth....................... (a) Born alive and now living....() Born alive but now dead......Stillborn FULL MAIDEN nump Residence (Usual place of abode Manual It non-resident, give place and State If non-resident, give place and State Color or race W (Years) Birthplace ..... (City/and State or County) (City and State or County) Occupation ..... Occupation .... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE I hereby certify that I attended the birth of this child, who was \Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn (Physician or midwife) child is one that neither breathes nor shows other evidence of life after birth.

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SEP 1 8 1930 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No ..... (If born in hospital or institution Prim. Registration District No. Local Registrar's No. 3 / give name.) FULL NAME OF CHILD .... (If stillborn, substitute the word "Stillbirth" for name of shild) Number Date of Legiti-Sex of Triplet in order birth ( of birth matel Child or other? (To be answered only in event of plural births) (Month (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead....... FULL MAIDEN NAME .... FULL Residence (Usual place of abode)... Residence (Usual place of abode) If non-resident, give place and State It non-resident, give place and State Color or race. Birthplace ... (City and State or County) and State or County Occupation Hause had CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature \*Where there was no attending physician? or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

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| (If death occurred in a hospital or institution, give                                                            | DO NOT WRITE IN THIS SPACE STATISTICS DEATH  State File No.  Local Registrar's No.  4 f  e its name instead of street and number.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
|------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| (a) Residence. No.  (Usual place of abode.)  Length of residence in city or town where death occurred. yrs. mos. | ds. How long in U. S. if of foreign birth? yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |
| PERSONAL AND STATISTICAL PARTICULARS  8. SEX                                                                     | MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  (Monty) (Day) (Year)  17. I HEREBY CERTIFY, That I attended deceas d from  19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
| 14.  Informant Acco Scar David (Address)  15.  Filed Leg 5                                                       | 19. Place of Burial, Cremation, or Removal  Date of Burial  20. Undertaker  Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |
|                                                                                                                  | PLACE OF DEATH  County of DEATH  (No. Primary Registration District No. Death occurred in a hospital or institution, give Death occurred in a hospital or institution, give Death of residence. No.  (Usual place of abode.)  Length of residence in city or town where death occured. The Death of residence in city or town where death occurred. The Death of Divorced (write the word.)  PERSONAL AND STATISTICAL PARTICULARS  3. SEX |  |  |

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| Place of Birth  County of Bonn & U.17e  City of Latio Falls.  Spencey Hospital. Registration District No. 23 State File No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |
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| FULL NAME OF CHILD.  Prim Registration District No.2 1 Local Registrar's No.2 2  FULL NAME OF CHILD.  (If stillborn, substitute the word "Stillbirth" for name of shild)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |
| Sex of Child Male of the Triplet or other?   and order of birth or other?   and of birth or other?   Legitimate?   Child Month   Child Month   Chay) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |
| What prophylactic was used to prevent Ophthalmia Neonatorum?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |
| Number of child of this mother, including present birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |
| FULL Untone James Schwarzen Berger Effa May McCowir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |
| Residence (Usual place of abode) Todato Falls Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |
| Color or race. White Age at last Birthday 3.6 Color or race. White Age at last Birthday 3.6 Birthplace Meril State or County Birthplace Weber Can you Wear's Birthplace Weber County Web County Weber County Web C |  |  |  |  |  |
| (City and State or County)  Occupation (City and State or County)  Occupation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |
| CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |
| I hereby certify that I attended the birth of this child, who was Stillborn at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |
| *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.  Address Address Filed 1 1930                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |
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DHACH TO HTATE OF BAHO. - UNITED TAKENT OF PURLIC WEEKLIRE SOUTHERNAU OR THAT STATISTICS CHICAGO OF BURTH Lettation Blaufet No. ..... State Pile R ordination of the tradition lute. Registration Datalet No. . . . Local Busic trur's No. this sillings, represented the word "Rightstein" for using of shirts -illuad "stau (I che aggared mis mere in principlicit it that prothylactic was used to prevent inhibituda Neonatorica? Residence I and place of abute .... page .... Hearten (Wing place of abode) mentioned with the chare and hard Heren elichtet, wer idere and Slote Wirthf lice . . . . . ring and state at country egeupation . ...... CHIRCH PARTY OF ATTENDING PHYSICS OF OR MUSICIPES

biseaby cornity that I attended the birth of this child, who was willborn for ....... on the date above stated.

> etc., should make this return. A stillborn child is one that nettern branther nor shows taken avidence of like efter birth

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| gr. →                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OCT 16 1930 DEPARTMENT OF PUBL                                                                                   | IC WELFARE DO NOT WRITE IN THIS SPACE                                                                                                                                                             |
| 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | BUREAU OF VITAL S                                                                                                |                                                                                                                                                                                                   |
| PHYSICIAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | PLACE OF DEATH                                                                                                   | DEATH                                                                                                                                                                                             |
| SIS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | County of D. A. A. C. Bogistration District No.                                                                  | 7 3 / 1/                                                                                                                                                                                          |
| E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | City ofL.d.O.H.OT.BT.L.S                                                                                         | ( 1 <del>L</del> EI                                                                                                                                                                               |
| . 💾                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                  |                                                                                                                                                                                                   |
| ; <b>;</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (No(No. institution, give                                                                                        | its name instead of street and number.)                                                                                                                                                           |
| C Fied                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2. FULL NAME Tucknoth                                                                                            | $\boldsymbol{J}$                                                                                                                                                                                  |
| XA<br>assi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | J. TOLL NAME                                                                                                     | - MA                                                                                                                                                                                              |
| E 10 / CI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (a) Residence. No.  (Usual place of abode.)  Length of residence in city or town where death occurred. yrs. mos. | (If nonresident give city or town and State.) ds. How long in U. S. if of foreign birth? yrs. mos. ds.                                                                                            |
| : tted erly                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Length of residence in city or town where death occurred. yrs. mos.                                              |                                                                                                                                                                                                   |
| sta<br>prop                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | PERSONAL AND STATISTICAL PARTICULARS                                                                             | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                      |
| CORD<br>CORD<br>Id be<br>y be p                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word.)                               | 16. DATE OF DEATH                                                                                                                                                                                 |
| GG<br>GGO<br>BIG<br>BIG<br>By b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | make white                                                                                                       | (Month) (Day) (Year)                                                                                                                                                                              |
| ING<br>REC<br>hould<br>may                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5a. If married, widowed, or divorced                                                                             | 17. I HEREBY CERTIFY, That I attended decess d from                                                                                                                                               |
| BINDING VENT RIGE Shot Lat it man it mant.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | HUSBAND of (or) WIFE of                                                                                          |                                                                                                                                                                                                   |
| OR BIND MANENT AGE s so that it important                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | - 1 1020                                                                                                         | , 19, to, 19                                                                                                                                                                                      |
| FOR RMA di. A so t imp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 6. DATE OF BIRTH (month, day and year)                                                                           | that I last saw h alive on                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | hrs. or                                                                                                          | and that death occurred, on the date stated above, as a proper to the DISEASE CAUSING DEATH, or in deaths from VIOLENT                                                                            |
| RVED F A PER supplied terms,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | SZ171 bornmin.                                                                                                   | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, ctate (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH* was as follows: |
| . હતું 002 ન                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 8. OCCUPATION OF DECEASED (a) Trade, profession, or                                                              | The CAUSE OF DEATH* was as follows:                                                                                                                                                               |
| RESE<br>IS IS<br>fully<br>plain<br>ION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | particular kind of work                                                                                          | stillsom, vanion                                                                                                                                                                                  |
| A TITLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (b) General nature of industry, business, or establishment in                                                    | 20selon to fumo                                                                                                                                                                                   |
| ARGIN<br>INK—T<br>be car<br>SATH in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | which employed (or employer)                                                                                     |                                                                                                                                                                                                   |
| MARGIN RESIDING THIS IN THE PROPERTY OF THE PR | (c) Name of employer                                                                                             | ds                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 9. BIRTHPLACE (city or town) Lasto Fatts (State or country)                                                      | ii                                                                                                                                                                                                |
| Shoul OF D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                  | CONTRIBUTORY (Secondary)                                                                                                                                                                          |
| : AI :                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 10. NAME OF FATHERU It one Janes                                                                                 | (duration)yrsmosde                                                                                                                                                                                |
| UNE DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Schwarzenberger                                                                                                  | 18. Where was disease contracted if not at place of death?                                                                                                                                        |
| S S S S S S S S S S S S S S S S S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11. BIRTHPLACE OF FATHER (city or town)                                                                          | Date of                                                                                                                                                                                           |
| tate in the section of the section o |                                                                                                                  | Was there an autopsy?                                                                                                                                                                             |
| E P S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 12. MAIDEN NAME OF MOTHER EXTAMA COWIN                                                                           | What test confirmed diagnosis?                                                                                                                                                                    |
| INLY<br>item<br>shoul                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 18. BIRTHPLACE OF MOTHER (city or town)                                                                          | (Signed) , M.                                                                                                                                                                                     |
| : + NIA V H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (State or County) Weber Caricon Istah                                                                            |                                                                                                                                                                                                   |
| `}<br>PL.<br>ver.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. Of the I following there                                                                                     | 19. Place of Burial, Cremation, or Removal Date of Burial                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Informant (Address)                                                                                              | Duche Julio lola digita 193                                                                                                                                                                       |
| 9 ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 15.                                                                                                              | 20. Undertaker Address                                                                                                                                                                            |
| ∞ ≱zi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Registra.                                                                                                        | none                                                                                                                                                                                              |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidmic cerebrospinal meningitis"); Diptheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia"); Lobar Pneumonia; Bronchopneumonia ("pneumonia," unqualified, is indefite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma. Sarcoma, etc., of ...... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

**DUTY OF LOCAL REGISTRARS**—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

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statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County BUREAU OF VITAL STATISTICS City CERTIFICATE OF BIRTH Registration District No...22 State File No... RETURN (If born in hospital or institution give name.) FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Sex of Date of Legiti-Triplet Child or other birth mate? (To be answered only in event of plural hirrie) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorim? Born alive but now dead..... Stillborn ..... FULL CITAL. MAIDEN NAME NAME numpe Residence (Usual place of abode) It non-resident, give place and ante If non-resident, give place and Stat Color or race Birthplace County) Occupation Occupation .... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. PLAINLY I hereby certify that I attended the birth of this child, who was | Stilling on the date above stated. (Signature) ..... \*Where there was no attending physician? or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Registrar.

ESTATE TO ULBANDE CRUPINICATION OF BIRTHE Eckistration district No. 4 of in Beels alon instrict Wal-FULL SAME OF CHILD telling to owner 1 "mummiss man and outlined of dilling all Cloth and years leath What prophylactic us meet to propent Ophthalipla Repnatoring Names of cales of this motion including present blith. 322..... in Born sivel and ross trong then the land won and with naut 是一川田川高橋 Color or care the same and the section Laken at last Birt dec Taking to be a madi THE PARTY OF THE PRESENTANT OF MENTION fullhere there was no attending physician or mittaile, then the father householder, cir. should make this return. A stillborn tally, is one that assider breathes nor thing maker wideness of the after birth

STATE OF IDAHO DO NOT WRITE IN THIS SPACE DEPARTMENT OF PUBLIC WELFARE RELIEVED HILL IN 1880 PHYSICIANS ement of 0C-BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No..... County of Borneselle Registration District No. Local Registrar's No. Primary Registration District No..... death occurred in a hospital or institution, give its name instead instead of street and number.) EXACTLY, (a) Residence. No..... (If nonresident give city or town and State) ds. How long in U. S., if of foreign birth? yrs. mos. ds. (Usual place of abode) Length of residence in city or town where death occurred vrs. mos. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 8 SEX 5 Single, Married, Widowed, or Divorced (write the word) 16 DATE OF DEATH 4 COLOR OR RACE newban should 5a If married, widowed, or divorced **HUSBAND** of HEREBY CERTIFY, That Lattended deceased from (or) WIFE of IS A AGE 6 DATE OF BIRTH (month, day and year) and that death occurred, on the date stated above. 7 AGE Years Months Days If LESS than day, The CAUSE OF DEATH\* was as follows: or 8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work... (b) General nature of industry, business, or establishment in which employed (or employer) ..... CONTRIBUTORY (c) Name of employer (Secondary) BIRTHPLACE (city or town) 18 Where was disease contracted if not at place of death?..... plain (State or country) No Date of Did an operation precede death?... 10 NAME OF FATHE Was there an autopsy? \_ of informatio E OF DEATH 11 BIRTHPLACE OF EATHER (city or town) What test confirmed diagnosis? (State or country) important. 12 MAIDEN NAME OF MOTHER \*State the DISEASE CAUSING DEATH, or in deaths from VIO-CAUSE LENT CAUSES, state (1) MEANS AND NATURE OF INJURY, 13 BIRTHPLACE OF MOTHER very (State or country) and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. Crestation, or Removal <u>.</u>2 Informant CUPATION (Address) shoul Registrar

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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| }                  | PLACE OF PRESURE IVED UC   10   930 STATE OF IDAHO                                                         |
|--------------------|------------------------------------------------------------------------------------------------------------|
|                    | County of Connewell DEPARTMENT OF PUBLIC WELFARE                                                           |
|                    | City of Salaho Jalla - BUREAU OF VITAL STATISTICS                                                          |
|                    | City of Santa 2/2 CERTIFICATE OF BIRTH                                                                     |
|                    | 1 . \ 10 / \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \                                                             |
|                    | No. 10. State File No. State File No. 184668  (15 here in hospital or institution                          |
| stated             | (If born in hospital or institution give name.)  Prim. Registration District No                            |
|                    | FULL NAME OF CHILD Stillbirth                                                                              |
| birth              | (If stillborn, substitute the word "Stillbirth" for name of child)                                         |
|                    | Sev of A Twin Number Legiti- Date of A A O                                                                 |
| of                 | Child or other? of birth mate? (1) birth sight dell 19.20                                                  |
| er                 | / (To be answered only in event of piural births) / (Morgan) (Day) (Year)                                  |
| order              | What prophylactic was used to prevent Ophthalmia Neonatorum?                                               |
| 4                  | Number of child of this mother, including present birth                                                    |
|                    |                                                                                                            |
| Don't any o day is |                                                                                                            |
|                    | FULL RAY PANIA AND NAME Sul Mal Jouver                                                                     |
| 0                  |                                                                                                            |
| namber             | Residence (Usual pilice of abode) Idaha falla, sadaho Residence (Usual place of abode) Idaha falla, sadaho |
|                    | It non-resident, give place and State                                                                      |
| 4                  | Color of race W. Age at last Birthday 43 Color of race. W. Age at last Birthday 49                         |
| t t                | (Years) (Years) (Years)                                                                                    |
|                    | City and State or Qunty)                                                                                   |
| Pu                 | Occupation                                                                                                 |
| D .                | CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.                                                             |
| each               | Born alive   10 15                                                                                         |
|                    | I hereby certify that I attended the birth of this child, who was Stillborn at 15                          |
| Ç                  | on the date above stated.                                                                                  |
|                    | (Signature)                                                                                                |
| •                  | (*Where there was no attending physician)                                                                  |
| ŀ                  | or midwife, then the father, householder, (Physician or midwife)                                           |
|                    | etc., should make this return. A stillborn Address Address Address                                         |
|                    | child is one that heither breathes not                                                                     |
| 4                  | (shows other evidence of life after birth.)                                                                |
|                    | Resistrar                                                                                                  |
|                    |                                                                                                            |

CHEADTMENT OF PUBLIC WELFARD ET REALL OF VITAL STATISTICS HERRY TO MESOTERATE Rushmulon Inarrict No....... State File dar nother man with the property of Frig. Rogi-trading District No. . . Social Registrar's No. ... CHE OF CHILD thing to come not "this word "stilled the name of the training Set of the control of Bas stophy hothe was used to prevent Ophthalmia Respatorum? n todillik. Born alive but now dead. . Hodrow. 自然程置方向 Scott bein grup place and Beat College ov races Age at last Birtist to Vortes ...... Age at last Birtist v Birthmere ..... Affire and State or same diringbace (Chy and Siste or County) rolling mile Geografion ... att. DESIGNATE OF ATTENDED PHYSICIAN OR MIDWIFES traine service

BL. Lair

Libershy certify that I attended the birth of this child, who was Stillborn ou the flate above states!.

(Signature) Shinese there were no attending physician : or midwife, then the father, house-solder, etc., should make this return. A stiffborn Address ..... child is our that neither breathes nor

shows other evidence of life after bitth.

OCT 1 6 1930 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No..... Registration District No..... Local Registrar's No. Primary Registration District No.... A PERMANENT RECORD should be stated EXACTLY, its name instead of street and number.) (If death occurred in a hospital (a) Residence. No..... (Usual place of abode) (If nonresident give city or town and State) word 15 D-S., if of foreign birth? Length of residence in city or town where death occurred PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH Single, Married, Widowed. 16. DATE OF DEATH 8. SEX COLOR OR RACE or Divorced (write the word) 5a. If married, widowed, or divorced HUSBAND of 17. I HEREBY CERTIFY, That I attended deceased from (or) WIFE of 6. DATE OF BIRTH (month, day and year) that I last saw h Days 7. AGE Years Months and that death occurred, on the date stated above, at 1030/0m The CAUSE OF DEATH\* was as follows: 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry. business, or establishment in (duration) \_\_\_\_\_yrs. \_\_\_\_mos. which employed (or employer) CONTRIBUTORY ..... (c) Name of employer (Secondary) \_\_\_\_\_(duration) \_\_\_\_\_yrs. \_\_\_\_mos. \_\_\_\_ds. BIRTHPLACE (city or town 18. Where was disease contracted (State or country) if not at place of death? 10. NAME OF FATHER Did an operation precede death? Date of Was there an autopsy? PARENTS 11. BIRTHPLACE OF FATHER (city What test confirmed diag (State or Country) \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 13. BIRTHPLACE OF MOTHER (city-or (State or Country) Cremation, or Removal Date of Burial Informant Undertaken Registra

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Do not accept a certificate of death signed only by a

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PLACE OF BIRTH STATE OF IDAHO County of CRECEIVED SEP 2 4 1930 DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No. /a P State File No. (If born in hospital or institution Prim. Registration District No. 2186. Local Registrar's No. 204 give name.) FULL NAME OF CHILD..... of birth (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number Date 6 Legiti-, Sex of Triplet in order and mate? yes birth & Child or other? (To be answered only in event of plural births) Month (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? FULL MAIDEN Residence (Usual place of abode) If non-resident, give place and State It non-resident, give place and State A at last Birthday Color or race. Birthplace Birthplace .... (City and State on County) City and State or County) Occupation Research Occupation .... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. PLAINLY case of mo I hereby certify that I attended the birth of this child, who was Stillborn at ...! on the date above stated. (Signature) \*Where there was no attending physician? or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

HIMM TOWART HTHIR WE MILE OF THE THE FTUP the state of the s inger Regist (top District Parameter Local Header are No. SHILL II the talk to one not thought a bear at the last April 1995 Line Company in laceto and rough the proxima state of the the same to the same of the sa in anti-leminent, wire obere beid Dat ... THE WALL TO SELECT Sin Spilland The second section of the second THE THE VALUE THE OWNER OF THE PARTY OF THE modified samedy blife will to strict out followers I and office design to . belone special state out mee. Laan musik the mention of the strength of es michriff, then becauter, househader; wir should arthe first settern A stillborn child is one that nellber breather nor shows other evidence of life after librit.

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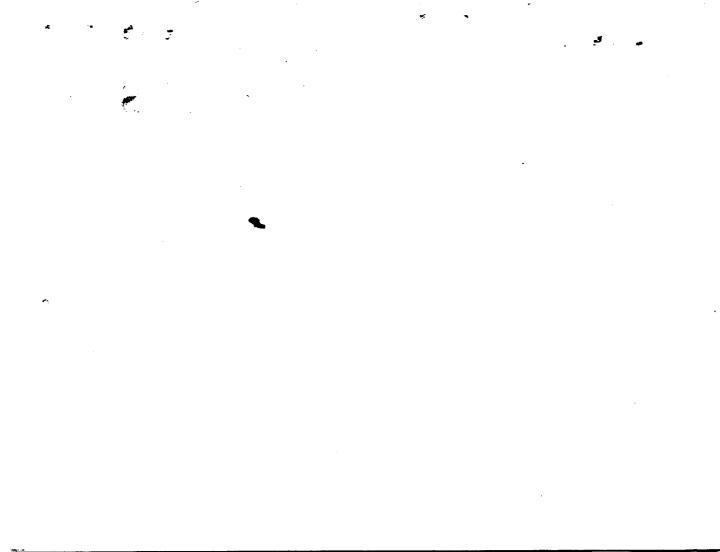
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DIVISION OF VITAL STATISTICS

DEPARTMENT OF COMMERCE BUREAU OF VITAL STATISTICS

C.K. MACEY SPECIAL AGENT

Boise, Idaho OCT 27 1930

184873

Mrs. D. Gomez BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT. DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

adam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed. for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

| mana                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Homes                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| DATE OF S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ept. 6, 1930                                        | SEX OF Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| orn to this mother or to the control of the control | r, including pro                                    | scnt birth 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| (Please write                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | plainly)                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C.K. Maccy Special Agent, Bureau of the Census,

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| RECEIVED OCT 1 0 1930                                                                                                                                                                                                                                                                                                  | STATE OF ID.  DEPARTMENT OF PUBLE BUREAU OF VITAL S  CERTIFICATE OF                                       | LIC WELFARE<br>STATISTICS                                                                                                                                                                                                                                                                      | DO NOT WRITE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | in this space                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
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| City of City of                                                                                                                                                                                                                                                                                                        | Registration District No                                                                                  | et No.                                                                                                                                                                                                                                                                                         | Local Registr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ar's No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 2. FULL NAME Balum  (a) Residence. No                                                                                                                                                                                                                                                                                  | 7                                                                                                         | s name instead of street s                                                                                                                                                                                                                                                                     | (If nonresident give city                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | or town and State) yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| PERSONAL AND STATISTIC  3. SEX  4. COLOR OR RACE  PERSONAL AND STATISTIC  3. SEX  4. COLOR OR RACE  PERSONAL AND STATISTIC  3. SEX  4. COLOR OR RACE  PERSONAL AND STATISTIC  3. SEX  4. COLOR OR RACE  PERSONAL AND STATISTIC  3. SEX  4. COLOR OR RACE  PERSONAL AND STATISTIC  3. SEX  4. COLOR OR RACE  PROBLEM 10 | 5. Single, Married, Widowed, or Divorced (write the word)  Seft 6 3 b  Day It LESS than 1 day hrs. o min. | 16. DATE OF DE  17. I HEREBY CE  that I last saw has and that death occur  The CAURE OF DI  CONTRIBUTORY (Secondary)  18. Where was dis if not at place if not at place Did an operation pr  Was there an auto What test confirmed (Sigmed)  *State the DISEA CAUSES, state (1 whether ACCIDEN | (Month) ( (Month | Day) (Year)  legased from  19.3  19.3  Ove, at  Seech  Daying mos.  which is a seech of the seec |

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Do not accept a certificate of death signed only by a

midwife.

| INK—THIS IS A PERMANENT RECORD birth a SEPARATE RETURN must be made for each, in order of birth stated. | City of St.  No. St.    55   50   494   Registration Dist   (If born in hospital or institution give name.)   Prim. Registration   FULL NAME OF CHILD   Company   Comp | brititute the word "Stillbirth" for name of child)  Legiti- mate? Co  (Month)  Local Registrar's No.  (19 20  (Year) |
|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| S a S                                                                                                   | Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Residence (Usual place of abode)                                                                                     |
| UNFAD<br>one child<br>number                                                                            | Color or race And Carlos Age at last Birthday (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Color or race ANALL Age at last Birthday 22  Rivthniace Od G A (Years)                                               |
| H H                                                                                                     | Occupation(City and Society Sounty)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (City and State or Country) Occupation                                                                               |
| PLAINLY WI                                                                                              | CERTIFICATE OF ATTENDIN  I hereby certify that I attended the birth of this chi on the date above stated.  (Sign  *Where there was no attending physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ature)  Reflect  at 10:30 9. M.  Stillborn at 10:30 9. M.                                                            |
| WRITE<br>N. B.—In                                                                                       | or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.  Address Filed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (Physician or midwife)  Pollolch  Aug 70 1930 gr gr. Thompso.                                                        |

| RECEIVED NOV 1 9 1930                                     |                                                                |
|-----------------------------------------------------------|----------------------------------------------------------------|
|                                                           | ATE OF IDAHO                                                   |
| BOARD OF HEALTH-                                          | BUREAU OF VITAL STATISTICS                                     |
| SUPPLEMENTA                                               | AL REPORT OF BIRTH                                             |
| Place City Street and House No.                           | Registered No. 65                                              |
| of Birth CountyLatak                                      | Registration Dist. No. 2145                                    |
| Sex of Child Genele.                                      | I Hereby Certify that the child described here has been named: |
| Date of Birth Quy 15 193 Father Charles, Querry FULL NAME | as reported by Wer Gharles. Giveny                             |
| Mother Bernsdine. O. Drwy.                                | Joseph Father or Mother Description Local Registrate           |



| RECORD EXACTLY, PHYSICIANS Kact statement of OCCUPA-                                             | PLACE OF DEATH  County of Mascaw City of Mascaw  (If death occurred in a hospital or institution, give                                                                                          | DO NOT WRITE IN THIS SPACE STATISTICS F DEATH  State File No                                                                                                  |  |  |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 2 Z                                                                                              | (a) Residence. No                                                                                                                                                                               | St. (If nonresident give city or town and State) ds. How long in U. S., if of foreign birth? yrs. mos. ds.                                                    |  |  |
|                                                                                                  | 8. SEX 4. COLOR OR RACE or Divorced (write the word)  White                                                                                                                                     | MEDICAL CERTIFICATE OF DEATH  16: DATE OF DEATH  Sept 18 1930  (Month) (Day) (Year)                                                                           |  |  |
| R BIN<br>IS IS<br>AGE<br>e prop                                                                  | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of  6. DATE OF BIRTH (month, day and year)  7. AGE Years Months Days If LESS than 1 da hrs.                                           | or                                                                                                                                                            |  |  |
| UNFADING INK—TH<br>be carefully supplied,<br>erns, so that it may habed, be back of certificate. | 8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer | The CAUSE OF DEATH* was as follows:  Aborton 3rd month  (duration) yrs. mos. ds.  CONTRIBUTORY Peritonitis. (Secondary)                                       |  |  |
| MA<br>WITH<br>should<br>t plain t                                                                | 9. BIRTHPLACE (city or town) Moreon 2da (State or country)                                                                                                                                      | (duration) yrs. mos. ds.  18. Where was disease contracted if not at place of death?  Did an operation precede death?  Date of                                |  |  |
| WRITE PLAINLY,<br>m of information<br>ISE OF DEATH in<br>portant. See instru                     | 10. NAME OF FATHER Alton Crowe  11. BIRTHPLACE OF FATHER (city or town) Grangevi. (State or Country) Idaho  12. MAIDEN NAME OF MOTHER Della Green                                               | Was there an autopsy?  What test confirmed diagnosis (Signed) , M. D.                                                                                         |  |  |
| WRITE item of important                                                                          | 12. MAIDEN NAME OF MOTHER Della Green  13. BIRTHPLACE OF MOTHER (city or town)  (State or Country)                                                                                              | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |  |  |
| 184941 B. B.—Every hould state C. ION is very                                                    | 14. Informant Altan Crawe (Address) Grangeville Idaha  15. Filed , 19 Registrar                                                                                                                 | 19. Place of Burial, Cremation, or Removal  Moscow  20. Undertaker  Address  Moscow  Address                                                                  |  |  |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

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MEET MAME OF COST,

Twin the control to the control of t Unite of Brith 195 That prophylard was used to merent spithaheia Neonatosum? sample of the marker including present burden. A. ... (4) Born alive and we live on Book alice not now load management of the property of the second of is non-good and over the own of the contraction of A Land of the contract of the contract of the state of th .... Miritipizee .... THEORY TO SEE THE THE medianjerosi) • अवार्षेताल केल अर्थ प्रथम । इन्यालक एक अल्ड वर्षे केनियमण 1 Continuente de I beardy cortify that I attended the bleth or this child, who was! stillborn on the date affect stated. I Where they create an attending property of i Physician er midwife) de inidwife, then the father, householder, utel, should make this return. All thous non in theire sail fon fait and at billio I tend to the till to go mid to the fit. Lively

Registrellen Derrict Money

L. State Mile No.

Frite. Revision District No. Local Registrar's So.

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| PHYSICIAN                                                                                                     | PLACE OF DEATH  County of Minidoka  City of Paul  STATE OF IDA  BUREAU OF VITAL S  CERTIFICATE OF  Registration District No.  Primary Registration District                                             | DO NOT WRITE IN THIS SPACE STATISTICS  DEATH  No. 20/2  Local Registrar's No.                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| stated EXACTLY.<br>operly classified.<br>ructions on back.                                                    | (No. (If death occurred in a hospital or institution, give  2. FULL NAME Baby Broadhead  (a) Residence. No. (Usual place of abode.)  Length of residence in city or town where death occured. yrs. mos. | St.  (If nonresident give city or town and State.) ds. How long in U. S. if of foreign birth? yrs mos. ds.                                                                                                                                                                                                                                         |
| ENT RECORD. GE should be state at it may be proper rant. See instruction                                      | PERSONAL AND STATISTICAL PARTICULARS  3. SEX 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorce (wide word.)  5a. If married, widowed, or divorced HUSPAND of                               | MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  Aug. 7 1930  (Month) (Day) (Year)  17. I HEREBY CERTIFY, That I attended deceased from                                                                                                                                                                                                            |
| RESERVED FOR BIN<br>IIS IS A PERMANEN<br>fully supplied. AGE<br>plain terms, so that<br>IION is very importan | (or) WIFE of  6. DATE OF BIRTH (month, day and year) Aug. 7 1930  7. AGE Years Months Days If LESS than 1 day. hrs. or Still Born min.  8. OCCUPATION OF DECEASED (a) Trade, profession, or             | that I hast saw h site built and 7, 1930.  that I hast saw h site built and 7, 1930.  and that death occurred on the date stated above at 8 Pm.  *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH* was as follows: |
| MARGIN IG INK—TH ould be care DEATH in                                                                        | particular kind of work                                                                                                                                                                                 | Pu-valal  (duration) yrs. mosds.                                                                                                                                                                                                                                                                                                                   |
| 99 T WITH UNFAL of information state CAUSE Exact statemen                                                     | 10. NAME OF FATHER Jabez Broadhead  11. BIRTHPLACE OF FATHER (city or town) Utah  12. MAIDEN NAME OF MOTHER Etta Curtis                                                                                 | (Secondary)  (duration) yrs. mos. ds.  18. Where was disease contracted if not at place of death?  Did an operation precede death?  Was there an autopsy?  What test confirmed diagnosis?                                                                                                                                                          |
| RITE PLAINLY, B.—Every item                                                                                   | 18. BIRTHPLACE OF MOTHER (city or town) (State or County)  14. Informant (Address)                                                                                                                      | 19. Place of Burial, Cremation, or Removal  Heyburn Ida Aug. 8 193  2. Undarate Address                                                                                                                                                                                                                                                            |
| **************************************                                                                        | 15. Filed Alf 1, 1930 SME Registrar.                                                                                                                                                                    | +N.6. Johnson Bully                                                                                                                                                                                                                                                                                                                                |

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ed EXACTLY, PHYSICIANS Exact statement of OCCUPA-STATE OF IDAHO RECEDED A POCT 8 DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No. Registration District No. Local Registrar's No..... Primary Registration District No. 15.2... RECORD a hospital or institution, give its name instead of street and number.) (Ladeath occurred Residence. No. (Usual place of abode) (If nonresident give city or town and State) How long in U. S., if of foreign birth? Length of residence in city or town where death occurred. mos yrs. mos. AGE should be st properly classified. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 16. DATE OF DEATH COLOR OR RACE Single, Married, Widowed, or Divorce (write the word) (Month) 5a. If married, widowed, or divorced HUSBAND of 17. I HEREBY CERTIFY, That I attended deceased from (or) WIFE of 6. DATE OF BIRTH (month, day and year) DE Days If LESS than 1 day, that it may certificate. and that death occurred, on the date stated above, at ..hrs. or min. 8. OCCUPATION OF DECEASED that (a) Trade, profession, or particular kind of work..... (b) General nature of industry. business, or establishment in (duration) \_\_\_\_\_vrs. \_\_\_\_mos. which employed (or employer) CONTRIBUTORY ... (c) Name of employer (Secondary) ....(duration) .....yrs, .....mos. Bhould plain instruction 9. BIRTHPLACE (city or town 18. Where was disease contracted (State or country) if not at place of death? \_ Did an operation precede death 220 Date of 10. NAME OF FATHER OF DEATH ant. See inst Was there an autopsy? ..... 11. BIRTHPLACE OF FATHER (city or t What test confirmed diagnosis? (State or Country) important. 12. MAIDEN NAME OF MOTHER item o \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT 18. BIRTHPLACE OF MOTHER (city or town CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (State or Country) state C Place of Burial, Cremation, Date of Burial Informant 19 (Address) LION Registrar

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Do not accept a certificate of death signed only by a

midwife.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS CERTIFICATE OF must desistration District No. (If born in hospital Prim. Registration District No. 2064 Local Registrar's No. give name.) FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of child) Number Sex of Date of Triplet Legitiand in order Childor other? birth ..... of hirth (To be answered only in event of plural births) (Month) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth. Born alive and how Born alive but now dead\_\_\_\_\_ Stillborn... FATHER FULL MOTHER FULT. MAIDEN NAME \_\_ Residence (Usual place of about) Residence (Usual place of abode) If nonresident, give place and State..... If nonresident, give place and State Color or race Color or race. Birthplace. ate or Country) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was \Stillborn on the date above stated. (Signature) case \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth. Filed. Registrar.



PLACEREBETHED OUT & STATE OF IDAHO 1930 County of Ite low DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH 185146 Registration District No. 77 State File No..... (If born in hospital or institution Prim. Registration District\_No.2176. Local Registrar's No.21 give name. FULL NAME OF CHILD... (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Sex of Date of Legiti-Triplet in order Child or other? mate? Hesbirth ....?. (To be answered only in event of plural births) (Month) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead ...... Stillborn \_\_\_\_ FULL MAIDEN NAME Residence (Usual place of abode) Residence (Usual place of abode) It non-resident, give place and State If non-resident, give place and State Color or race. (City and State or County) Oly and State or County) Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was L Stillborn case of on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MULTAL STATE STATES THE TO STANFORM AND A Beging allow Walter No. restall the methalisment it and Princ. Registrepton Married Man. Local Russ of the No. (If selfsor agential to went stilled to went stillbird to appear of the collection o I.Mugrour Date of Legith To be seen cross unity in sweet of places birthes. The property was used to stere of Ophicalaila Neumatorum? the manual with mother, besideing our sent high the same after any mother with the same of . .... Ineli won the wither J. F. F9 Rentrice Lies page of storic suggestions of the contract of th the said and desired the said and desired to the The state of the state of the Sologi or anio which are the statement best firster of TOTAL STATE OF COLUMN Mark Blate and Trails The and State or County DESCRIPTION DE PROPERTY CHRYLEREARS, GO. ATTUENDING PHYSICIAN OR MIDWIRE. THE THIRD Therefor coulds than I attended the lighth of this child, who was I fillinged on the title shown stared. casion (in antibooile on say will similar or madwife, then the father, householder, Cist. should night this return. A sufficient child to one that autitor profities one above other exidence of less their Miles.

| 82 1                                                   | RECEIVED OCT 8 1980 STATE OF IDA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | но                                                                                                                |
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| Z Z                                                    | DEPARTMENT OF PUBLI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                   |
| 55                                                     | PLACE OF DEATH BUREAU OF VITAL ST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1 DO MOI WILL IN THIS STROET                                                                                      |
| PHYSICIANS: of OCCUPA-                                 | CERTIFICATE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                   |
| H C                                                    | County of 11 le le le                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | • • • • • • • • • • • • • • • • • • •                                                                             |
| E 3                                                    | City of Dictor Registration District No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Local Registrar's No                                                                                              |
| Y,                                                     | Primary Registration District                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | No                                                                                                                |
|                                                        | (No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                   |
| # CE                                                   | (If death occurred in a hospital or institution, give its                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | name instead of street and number.)                                                                               |
| RECORD<br>EXACT<br>Kact state                          | 2. FULL NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | · <b>,</b> ~                                                                                                      |
| REE                                                    | 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   |
| 두 결절                                                   | (a) Residence, No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (If nonresident give city or town and State)                                                                      |
| ENT RECORD<br>stated EXACTLY,<br>d. Exact statemen     | Length of residence in city or town where death occurred. yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | How long in U. S., if of foreign birth? yrs. mos. ds.                                                             |
| NG PERMANENT tould be state g classified. E            | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                      |
| d l<br>ass                                             | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 16. DATE OF DEATH                                                                                                 |
| ING<br>PERN<br>should<br>rly clas                      | male White or Divorced (write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Defit 13 180                                                                                                      |
| E de de                                                | 5a. If married, widowed, or divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Month) (Day) (Year)                                                                                              |
| BINDIN<br>IS A P<br>AGE sh<br>properly                 | HUSBAND of (or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 17. I HEREBY CERTIFY, That I attended deceased from                                                               |
| BINI<br>IS A<br>AGE<br>prope                           | (01) WIFE 01                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Sept 13 , 1930, to Sept 18 , 1930                                                                                 |
| e E                                                    | 6. DATE OF BIRTH (month, day and year) 4 - (3 - 1990)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | that I last saw he alive on 19                                                                                    |
| FOR<br>THIS<br>ed. 4<br>y be 1                         | 7. AGE Years Months Days If LESS than 1 day,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | and that death occurred, on the date stated above, at/ 2 Wm.                                                      |
|                                                        | hrs. or min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | The CAUSE OF DEATH* was as follows:                                                                               |
| RVE<br>INK<br>sup<br>it i                              | 8. OCCUPATION OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Anallowation                                                                                                      |
|                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | monstrosity                                                                                                       |
|                                                        | (a) Trade, profession, or particular kind of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   |
| N RES<br>FADINC<br>carefull<br>s, so th                | (b) General nature of industry,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (duration) yrs, mos, ds.                                                                                          |
| Z Z Z Z                                                | business, or establishment in which employed (or employer)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                   |
| RGIN RESE<br>UNFADING<br>be carefully<br>erms, so than | (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CONTRIBUTORY (Secondary)                                                                                          |
| 4 76                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (duration) yrsmosds.                                                                                              |
| M.WITH<br>WITH<br>Should<br>plain<br>ction             | 9. BIRTHPLACE (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 18. Where was disease contracted                                                                                  |
| B. Sh                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | if not at place of death?                                                                                         |
| PLAINLY,<br>nformation<br>DEATH in<br>See instr        | 10. NAME OF FATHER Til Blaucher                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Did an operation precede death? Date of                                                                           |
| NL<br>atio<br>TH<br>ins                                | THE PROPERTY AND ON PARTY IN A STATE OF THE PARTY IN A | Was there an autopsy?                                                                                             |
| PLAI<br>form<br>DEA                                    | 11. BIRTHPLACE OF FATHER (city or town) (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | What test confirmed diagnosis?                                                                                    |
| 로 월 <sup>[2</sup> 8]                                   | Lictor ada.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (Signed) userusuu, My D.                                                                                          |
| TE<br>of i                                             | (State or Country)  12. MAIDEN FAME OF MOTHER  12. MAIDEN FAME OF MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 9-14-, 1930 (Address) waggo of da                                                                                 |
| WRITE<br>m of j<br>JSE OF<br>portant                   | Swary & Comman                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <del></del>                                                                                                       |
| WRI<br>item c<br>AUSE<br>import                        | 18. BIRTHPLACE OF MOTHER (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) |
|                                                        | walt Lake Wale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                 |
| very<br>ate C                                          | 14. Informant Wallace J. Blanchard                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 19. Place of Burial, Cremation, or Removal Date of Burial                                                         |
| -Ever<br>state<br>is ver                               | (Address) // Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Victor, Ida 9-14-1930                                                                                             |
| السا                                                   | A THE COLUMN ASSESSMENT OF THE COLUMN ASSESSME | 20. Undertaker Address                                                                                            |
| N. B. Should                                           | 15. Filed 10 - 4 - 1930 Martha Marker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | AMULUO                                                                                                            |
| 7.4E                                                   | Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                   |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife. Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid lise of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs. Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere chopheumonia (secondary), 10 gs. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PHERPERAL sention": "PHERPERAL peritor as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

168-211-041-396 PLACE OF EIRFEID 1930 STATE OF IDAHO County of ... DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS City of thementon CERTIFICATE OF BIRTH Registration District No...77 State File No..... (If born in hospital or institution Prim. Registration District No. 2176. Local Registrar's No. 26 give name.) FULL NAME OF CHILD.. (If stillborn, substitute the word "Stillbirth" for name of child) Date of Q\_ Number Sex of Legiti-Triplet and din order Child or other? birth mate Hes (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead Stillborn FULL MOTHER . FULL MAIDEN NAME ... Residence (Usual place of abode) 10 lennen 13 10 It non-resident, give place and State If non-resident, give place and State Color or race .. Color or race / // Age at last Birthday, Birthplace (City and State or County) (City and State or County) Occupation habrasely Occupation # CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. Born alive I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or misuite etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

AND THE DEPOSIT OF THE SECOND CERTIFICATION ALLES Healstratine Weight Boundaries THE MER Prince Restriction District No. 41 Land Registrate N. The a cobsession the word "Mitthirth for annic Cabilly Date of 11.49 and to the state of the state o the sense was used to proven to birtishmia Vonascinius? the of the court o navalli (4.... arms after het new don't MOTRICK : LE STOR Problems Varial Manual States of the States Butter of the day of the same to the soul service of the soul service service services place base of the property and the contract he guidants for the safety of the same in sofar). Birtholo is the and grace in country TOWN TO MINT TON THE PARTY Description of Land and Land CHETISTIAN ATTEMPTED DITTEMPTS OF MENTERS i office anoth: Efficient earthy that I untended the birth of this child, who was sullinous jut . to the space stated. THE PROPERTY WAS BUILDING THE PROPERTY OF THE (Alex New Section (Alex) or minutes, then the lather, houseleder elv steeld make tien referre. A stillboin TOR A DECEMBER TRACES THAT ONE W DIDE allows other exidence of his street pirth.

| S .                                                      | STATE OF IDA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | AHO                                                                                                                                                           |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| API                                                      | RECEIVED ACT 8 1024 DEPARTMENT OF PUBL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | IC WELFARE DO NOT WRITE IN THIS SPACE                                                                                                                         |
| 55                                                       | PLACE OF DEATH BUREAU OF VITAL S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                               |
| YSICIAN<br>OCCUPA                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DEATH State File No. ( & 1 : 1)                                                                                                                               |
| PHY<br>of C                                              | County of Registration District No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |
| A to                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                               |
| Υ,<br>ien                                                | City of Level Primary Registration District                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | t No.1.1                                                                                                                                                      |
| ECORD<br>EXACTLY<br>ct stateme                           | (No(If death equipment in a hospital or institution, give its                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | )                                                                                                                                                             |
| AC<br>tat                                                | (If death occurred in a hospital or institution, give its                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | s name instead of street and number.)                                                                                                                         |
| RECORD<br>EXACT<br>act state                             | 2. FULL NAME Stillborn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~                                                                                                                        |
| RE<br>E<br>Kac                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | G4.                                                                                                                                                           |
| F 25 63                                                  | (a) Residence. No(Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (If nonresident give city or town and State)                                                                                                                  |
| EN<br>d.                                                 | Length of residence in city or town where death occurred. yrs. mos. ds                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | . How long in U. S., if of foreign birth? yrs, mos. ds.                                                                                                       |
| NG<br>PERMANENT<br>hould be state<br>y classified. F     | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |
| GRMA]<br>uld be<br>classifi                              | 8. SEX 4. COLOR OF RACE 5. Single, Married, Widowed,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 16. DATE OF DEATH                                                                                                                                             |
| ING<br>PERI<br>should                                    | Hemal White or Differed (write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 9 11 1930                                                                                                                                                     |
| BINDIN<br>IS A P<br>IGE sho<br>properly                  | 5a. If married, widowed, or divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Month) (Day) (Year)                                                                                                                                          |
| BINDIN<br>IS A F<br>AGE sh<br>properly                   | HUSBAND of<br>(or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                           |
| BIN<br>IS<br>VGE<br>prop                                 | (or) with a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 9-11 , 1930, to 9-11 , 1930                                                                                                                                   |
| R IS                                                     | 6. DATE OF BIRTH (month, day and year) 9- //- //30                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | that I last saw h alive on 19                                                                                                                                 |
| FOR THIS ed. /                                           | 7. AGE Years Months Days If LESS than 1 day,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | and that death occurred, on the date stated above, at 4 36 m.                                                                                                 |
|                                                          | hrs, or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | The CAUSE OF DEATH* was as follows:                                                                                                                           |
| RVED<br>INK-<br>supplificat                              | 8. OCCUPATION OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Willborn 1 Campuse                                                                                                                                            |
| まっ しかれ                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1815-mp) 6 mg                                                                                                                                                 |
| S P S S S S S S S S S S S S S S S S S S                  | (a) Trade, profession, or particular kind of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | o. B. Mar                                                                                                                                                     |
| A RESE<br>ADING<br>arefully<br>80 tha                    | (b) General nature of industry.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | · · · · · · · · · · · · · · · · · · ·                                                                                                                         |
| FA]                                                      | business, or establishment in which employed (or employer)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (duration)yrsmosds.                                                                                                                                           |
| RGIN<br>UNF/<br>be ca<br>erms,<br>n bac                  | (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CONTRIBUTORY                                                                                                                                                  |
| <b>→</b> → 6                                             | (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Secondary)                                                                                                                                                   |
| MA<br>TTH<br>TTH<br>iould<br>lain<br>ion                 | 9. BIRTHPLACE (city or town) Samenthile                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (duration)yrsmosds.                                                                                                                                           |
| WITI<br>WITI<br>shoul<br>plair<br>ction                  | (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 18. Where was disease contracted if not at place of death?                                                                                                    |
| I.E.E                                                    | 10. NAME OF FATHER &                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Did an operation precede death?                                                                                                                               |
| PLAINLY, information bEATH in See instru                 | barl Ohnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Was there an autopsy?                                                                                                                                         |
| n a T                                                    | 11. BIRTHPLACE OF FATHER (city of town) MI (Cleasan)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | What test confirmed distributions ?                                                                                                                           |
| PLAI<br>form<br>DEA'<br>See                              | (State or Country) Wash                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (Signed) Jarkyson, M. D.                                                                                                                                      |
| T iii                                                    | Near                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 9-12- 1930 (Address) Durgo Dedw                                                                                                                               |
| WRITE   item of ir                                       | 12. MAIDEN NAME OF MOTHER Thalma Lione                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Address)                                                                                                                                                      |
| VRI<br>SE<br>port                                        | 18. BIRTHPLACE OF MOTHER (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT                                                                                                   |
| a de de de                                               | (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL. |
| . CA.                                                    | a Caralan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                               |
| Every in state CA                                        | 14. Informant Carl Johnson:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 19. Place of Burial, Cremation, or Removal Date of Burial                                                                                                     |
| \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ | (Address) La contact de la Con | Clementsville Id 9-19- 1938                                                                                                                                   |
|                                                          | The state of the s | 20. Undertaker Address                                                                                                                                        |
| OFF                                                      | 16. Filed 10-4-, 1930 Martha Marker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                               |
| z g E                                                    | Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                               |

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spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of ...... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
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Do not accept a certificate of death signed only by a

midwife.

head of "Contributory."

1930 PLACE OF STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS City of. CERTIFICATE OF BIRTH Registration District No..... .....State File No. (If born in hospital or institution Prim. Registration District No. 1004 Local Registrar's No. 520 give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Sex of Legiti-Date of Triplet and in order Child birth or other? mate 401 (To be answered only in event of plural births) (Month) (Dav) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth................ (a) Born alive and now living...... Born alive but now dead......Stillborn ...... MAIDEN NAME Residence (Usual place of abode).... Residence (Usual place of abode) Of post-resident, give place and State (City and State or County) Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was | Stillborn on the date above stated. \*Where there was no attending physician? or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife) . .. sullborn

.... other evidence of life after birth.

STATE OF IDAHO DO NOT WRITE IN THIS SPACE DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS State File No. ..... PLACE OF DEATH CERTIFICATE OF DEATH County of..... Registration District No. ..... Local Registrar's No. Primary Registration District No. 1005 (If death occurred in a hospital or institution, give its name instead of street and number.) 2. FULL NAME ..... (If nonresident rive city or How long in U. S. if of foreign birth? yr (a) Residence. No. ..... mo: (Usual place of abode.) mo 1. Length of residence in city or town where death occured MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 16. DATE OF DEATH Single, Married, Widowed, Divorced (write the word) (Year) (Day) (Month) 17. I HEREBY CERTIFY, That I attended deceas d from 5a. If married, widowed, or divorced HUSRAND of (or) WIFE of 6. DATE OF BIRTH (month, day and year) and that death occurred, on the date stated above, at..... If LESS than 1 day, Months Days 7. AGE \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH\* was as collows: ....hrs. or ....min. 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer (duration) \_\_\_\_\_yrs, \_\_\_\_mos, \_ 9. BIRTHPLACE (city or town) (State or country) CONTRIBUTORY ..... (Secondary) \_\_\_\_\_\_(duration) .....yrs, \_\_\_\_\_mos. \_ Where was disease contracted if not at place of death?..... 11. BIRTHPLACE OF FATHER (city or town)......(State or Country) Did an operation precede death?... Was there an autopsy?. 12. MAIDEN NAME OF MOTHER What test confirmed dis 13. BIRTHPLACE OF MOTHER (city or town)..... (State or County) Date of Burial Place of Burial, Cremation, Informant (Address) Registrar.

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Here the transfer to the trans of exemple the second of the second of the the student of the state of the Logist Pe abient of to prevent Opinhalust Seconstorius? Burn alfre but now read a will Between Base | State | Manufacture of the state of the Constitution in the contract to 20100 Condition of the contract of the contrac AC caneral and the control of the co THE THE CATE OF ATTIMINED PHYSICIAN OR MILWING Limenty correly that I arranded the hirth or this child, who was I stillment for on the clute since water (Menature) Photoire there was no attending obygician or midwife, then the father, householder, Can And last de miquelas. etc. should make the return. A stillings child is one that he take averthee nor direct order at the state of the

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| PERMANENT RECORD RETURN must be made for | City of Ario                                                                                                                     | STATE OF IDAHO ARTMENT OF PUBLIC WELFARE UREAU OF VITAL STATISTICS  CERTIFICATE OF BIRTH 185374  rict No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| ERM                                      | FULL NAME OF CHILD                                                                                                               | ostitute the word "Stillbirth" for name of child)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |
| <b>⋖</b> 열.                              | Sex of Triplet and or other?  Child Male Triplet and of birth (To be answered only in event of plural b                          | Legitify Date of Oct 15 1930 (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |
| S IS                                     | What prophylactic was used to prevent Ophthalmia Neonatorum?                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
|                                          | Number of child of this mother, including present birth 4 (a) Born alive and now living 3                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| انسا                                     | Born anve but now dead                                                                                                           | Stillborn MOTHER /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |
| E t                                      | FULL H. Kalth Lewis                                                                                                              | MAIDEN Martha Kaufman                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |
| ADING<br>tild at bi                      | Residence (Usual place of abode).                                                                                                | Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |
| AD                                       |                                                                                                                                  | If nonresident, give place and State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |
| UNFAD<br>one child                       | Color or race Whee Age at last Birthday (Years)                                                                                  | Color or race Age at last Birthday (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
|                                          | Birthplace                                                                                                                       | Birthplace (City and State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
| WITH<br>than                             | CERTIFICATION OF APPROVED                                                                                                        | Occupation Provided August 1997                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| - e                                      | I hereby certify that I attended the birth of this child, who was Stillborn at 8.40 C. M. on the date above stated.  (Signature) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| PLAINLY V                                |                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| PLA<br>case                              | *Where there was no attending physician or midwife, then the father, householder,                                                | Paris Defalis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
| H                                        | detc., should make this return. A stillborn                                                                                      | (Physician or midwife)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
| WRITE<br>B.—In                           | child is one that neither breathes nor shows other evidence of life after birth.                                                 | the same of the sa |  |  |
| ż                                        | shows other evidence of the after birth.                                                                                         | Registrar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
|                                          |                                                                                                                                  | ask runted arm veg                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |

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PLACE OF THE NOV 1 0 1930 STATE OF IDATIO Bingham DEPARTMENT OF PUBLIC WELFARE County of.... BUREAU OF VITAL STATISTICS City of Baackfoot CERTIFICATE OF BIRTH No. M. Oak St. 185400 Registration District No. 2 State File No. 168 172-006-813 (If born in hospital or institution Prim. Registration District No. 20 Local Registrar's No. 342 give name.) Alton Johnson FULL NAME OF CHILD .... (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number Legiti-Date of Sex of Triplet in order mate?ves hirth ... Child or other? Male (To be answered only in event of plural births) (Month) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead......Stillborn 1 FULL Lional Johnson FULL MAIDEN Mary Hatch 11113011 Residence (Usual place of abode) Blackfoot Residence (Usual place of abode) Blackfoot If non-resident, give place and State It non-resident, give place and State Color or race white Age at last Birthday 27 Oklahoma Birthplace Hteh Tdaho. (City and State or County)
Occupation Section Land HCity and State or County) Occupation 11/1436WILEO CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was Stillborn on the date shove stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor Address / shows other evidence of life after birth.

DELYZIALENE OF SERENCE RESTER in Mande CHECK STREET, Det Derteil interior of refried Mentales Nos Control of the Nos (4 stillbern, substitute the word swinding to " CHACH Calific lavel, to the end of the lavel of the That monarlastic van med or present Ophthalmia Nematorum tel Born Mive authonou hayage Turnium of the in the market laddening present vittig arndline Burn Stive but ber dend MATCHEN MAXIE Heridebon (Usual place of about than design the place of the same will be a second If non-secreterit, give piece and Bate College of theco Birthplace . .. Tyling of the day the (City and shows of the country) Orcelination. Georgeanou ... DESCRIPTION OF ASTERNIAN PHYSICIAN OR EXCHANGE Liberthy certify that I attended the birth of this child, who was Stillborn on the state shorts stated. Michaeure ( Michael Committee)

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of individe the the father, householder, or stoud make this seaten. A still born

child is one that actiber brokhes and shows out a cridence of life after Milh

STATE OF IDAHO PHYSICIAN
of OCCUPA DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No. Registration District No..... Local Registrar's No. . . . . . . . . . . . . Primary Registration District No. A PERMANENT RECORD should be stated EXACTLY, (No. ....death occurred in a hospital or institution, give its name instead of street and number.) 2. FULL NAME.. (a) Residence, No. (If nonresident give city or town and State) (Usual place of abode) How long in U. S., if of foreign birth? Length of residence in city or town where death mos. mos. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 5. Single, Married, Widowed. 16. DATE OF DEATH 8. SEX or Divorced (write the word) 5a. If married, widowed, or divorced HUSBAND of I HEREBY CERTIFY, That I attended deceased from. (or) WIFE of 6. DATE OF BIRTH (month, day and year) If LESS than 1 day, 7. AGE Years Days Months and that death occurred, on the date stated above, at..... \_hrs. or was as follows: 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer) terme CONTRIBUTORY ..... (c) Name of employer (Secondary) (duration) yrs. mos. 9. BIRTHPLACE (city or town 18. Where was disease contracted if not at place of death? (State or country) Did an operation precede death?...4 Was there an autopsy? ...... 11. BIRTHPLACE OF What test confirmed diagresis? (State or Country) (Signed) \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE O (State or Countr Date of Burial Informant (Address) Address

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough: Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Chall," "Ulancia," "Wallessen," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis." etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident: Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

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(Year)

PLACE OF BIRTH

or other?

Where there was no attending physician;

and wife, then the father, householder, e and should make this return. A stillborn I one that neither breathes nor shows other evidence of life after birth.

and in order

I hereby certify that I attended the birth of this child, who was! Stillborn

(To be answered calv in event of plural births)

State ....

of birth

(Years)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

And the complete of the conference 
(Years)

Registrar

bitth ..... 19.... 19....

(Month) (Day)

MOTHER

Residence Usual place of aboute

If non-real test, give a lace and litate 

Rirthplace ..... (City and State or County)

(Physician or midwife)

Rorn allve

Registration District No......State File No....

(If stillborn, substitute the word "Stillbirth" for name of child)

Prim. Registration District No......Local Resistrat's No.....

Legiti-

mate?

VAMIS .... .... .... .... VAVIS

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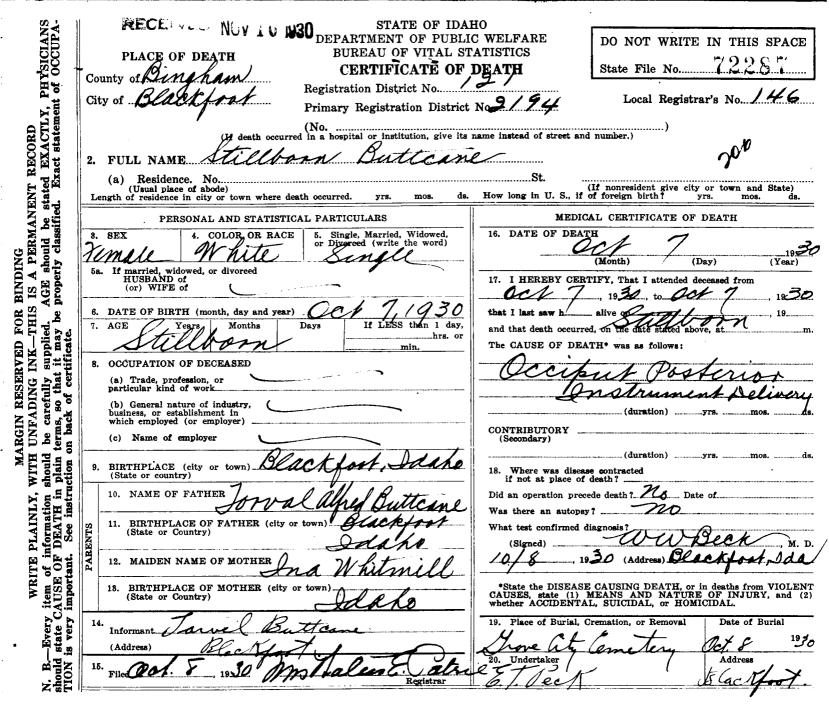
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| FADING INK—THIS IS A PERMANENT RECORD e child at birth a SEPARATE RETURN must be made number of each, in order of birth stated. | PLACE OF BIRTH  County of State OF IDAHO  NOV 1 0 1930 DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS  CERTIFICATE OF BIRTH  185431  Registration District No State File No Sta |
|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                 | Number of child of this mother, including present birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                 | Born alive but now dead                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                 | FULL Towal Whed Buttone NAME Ina Whitmill                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                 | Residence (Usual place of abode) Planford - RT 3 Residence (Usual place of abode) Hanthowt 023,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| FA<br>oct                                                                                                                       | It non-resident, give place and State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| UNE none                                                                                                                        | Color or race Whyle Age at last Birthday 22 (Years) (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| ITCH<br>than<br>and ti                                                                                                          | Birthplace (City and State or County)  Birthplace (City and State or, County)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                 | Occupation Scale Occupation Occupation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| ILY<br>mor<br>each                                                                                                              | I hereby certify that I attended the birth of this child, who was Stillborn at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| PLAINLY<br>case of m<br>for ear                                                                                                 | on the date above stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| PL                                                                                                                              | (Signature)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| E L                                                                                                                             | (*Where there was no attending physician or midwife, then the father, householder,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| WRITE<br>B.—In                                                                                                                  | etc., should make this return. A stillborn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Z.                                                                                                                              | child is one that neither breathes nor shows other evidence of life after birth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>F</b> 4                                                                                                                      | Filed 19-10 Registrar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

- THE PROPERTY OF THE PARTY OF RUTATE JAMES TO GARRIES Registration Bulget No. 4 ... State The No. Trun. Hegistradio Dientel Note 2 Local Bellets It stills a sovetitute the word "Stillette" for name of the Traignute. Legit Thurs at busy SSTROIT march lo ! of president was need to prevent Ophibalicia Scountorning Country of wild of this mother, fielding present that were all the and new leve estion alive but now don'd ALC: 131 MATORS ANAME . SHARA. Residence Count place of abodial Wassersident, give place and State ..... in make the make the will be to Color or race of the page 41 last Blether conditional se up a sala and the control of BUNDANCE .... Profit Edition 15 INCHEST OF CERTIFICATE OF ACTION OF THERESAL OR STRUCTURED Edwards certify that I attended the birth of this child, who was Billiborn the late when a state of essinger, there, was no attending wheelen ii recombiardia. or ulderly the tather discounder. etc. should make this rotary. A stillhoon child is one that newfier broathest nor share other evidence of the star birth



STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine. etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs. meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

PLACE REPRIN STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of Denaham BUREAU OF VITAL STATISTICS City of Accompany CERTIFICATE OF BIRTH -185435 Registration District No. . . . . . . . . . . . State File No. . . . (If born in hospital or institution Prim. Registration District No. 32/94 Local Registrar's No. 52 give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Number Twin Date of Legiti-Sex of Triplet in order hirth Child or other? mate \( \) (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead Stillborn Da FULL MAIDEN Residence (Usual place of abode) Residence (Usual place of abode). If non-resident, give place and State It non-resident, give place and State Color or race Birthplace ...... (City and State or County) (City and State or County) Occupation . CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician WRITE or midwife, then the father, householder. etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Registrar.

Losephention Marriet No. Conf. Conf. Marriet No. fim. Restriction District Money Commission of the The series to minima the state of the sea and the sea series of the season of season · PARTIT mind to Har to more an vine bearing on the case What acquisite was used to mevent (whitest als Noonstorus) A supplied of this mather, including present via legal to minimize Born alive and rev length had non ind wife that 101111 PATHER KHGIAM and the state of t . Martingla. Suno to state and the country (City and River or cantro) · Bollmanner' TRATIFICATE OF AFTURING PHYSICIAN OR MOWIES Livering sectify that I attended the high of this child, who was fullinger in the their chair states, Comme there was an attending attended egranderies then the father description.

The should nake this potation A efficient

the should nake this potation and the nor Charte ion or judgette About the middle and the second

NOV I O 1830 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH State File No..... CERTIFICATE OF DEATH Registration District No..... Local Registrar's No. 1.4 Primary Registration District No ... (No. A PERMANENT RECORD (If death occurred in a hospital or institution, give its name instead of street and number.) (a) Residence. No......St. (Usual place of abode) (If nonresident give city or town and State) ds. How long in U. S., if of foreign birth? Length of residence in city or town where death occurred. mos. yrs. mos. classified. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 5. Single, Married, Widowed, or Divorced (write the word) 16. DATE OF DEATH SEX OR RACE (Day) 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of 17. I HEREBY CERTIFY, That I attended deceased from 6. DATE OF BIRTH (month, day and year). 7. AGE Days If LESS than 1 hat it may certificate. and that death occurred, on the date stated above, at The CAUSE OF DEATH\* was as follows: 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer) (duration) \_\_\_\_\_yrs. \_\_\_mos. \_\_\_ CONTRIBUTORY (c) Name of employer (Secondary) (duration) yrs. mos. ds. 9. BIRTHPLACE (city or town)
(State or country) 18. Where was disease contracted if not at place of death? ... 10. NAME OF FATHER Did an operation precede death? OF DEATH Was there an autopsy? 11. BIRTHPLACE OF FATHER (city What test confirmed diagnosis: (State or Country) CAUSE OF important. \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE OF MOTHER (city or town (State or Country) of Burial, Cremation. Date of Buria Informant Addresi Registrar

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

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cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia." "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning:

spinal fever (the only definite synonym is "Epidemic

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struck by railway train-accident; Revolver wound of

head-homicide; Poisoned by carbolic acid-probably sui-

cide. The nature of the injury, as fractured skull, and con-

sequences (e. g. sepsis, tetanus) may be stated under the

head of "Contributory."

STATE OF IDAHO 1930 County of Bonner DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS City of Sandhoint Ida CERTIFICATE OF BIRTH Registration District No. 76 State File No. (If born in hospital or institution Prim. Registration District No. 2155. Local Registrar's No. 142 give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number Sex of Date of Legiti-Triplet in order mate? Les Child Male birth ... (To be answered only in event of plural hirths) What prophylactic was used to prevent Ophthalmia Neonatorum? Silver-77:172te Born alive but now dead......Stillborn FULL MAIDEN Pachel Caroline Jacobson Residence (Usual place of abode) Sand Jaaint Icla. Residence (Usual place of abode) 52764 /2017 It non-resident, give place and State (City and State or County) Occupation Pancher Occupation Hause Wile CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. \*Where there was no attending physician or midwife, then the father, householder, (Physician of midwife) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STARRED IDAILU POPPETTATE STATISTICS Registration Matriet No. notikiting in latit went man Prim Registration District No. ... Local Registrack Sta. COLE IN CHIED II achore, subarttute the word "Bittigers" for name of chiat) THUMBER! and in perior (Take suppered soly as several place births) (Almost) the was used to prevent Ophthalinia Secustorius? Auditor of cariforn the mother, converted present both configuration at him lives theme. Burn phys but now dead. Parisher of the state of the st It some entrul, give there and from announcement the contract of the A Service of Heritaphore of Colores State of Councer) Domination Comparison CERTIFICATE OF ATTENDING DESCENAS OR MEASURE. Themes, easily that he strouged the high of this child, also was Settlemen Jointe should stall sall stall (Signalar) Swiftere there was no attendingentrysicion (Physician of miletra) the author then the lather householder. eir, should make this return, & stillborn ACT OF THE PARTY O did to ope that petter breather nor strict rolls with to emobite the pitch - Carbonal Control

| ¥ S                                                                    | RECEINOV 7 1930 STATE OF IDAI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | HO                                                                                                                                                            |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PHYSICIAN<br>t of OCCUPA                                               | DEPARTMENT OF PUBLIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                               |
| ಶಶ                                                                     | PLACE OF DEATH BUREAU OF VITAL ST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                               |
| SI<br>SI                                                               | CEPTIFICATE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | DEATH State File No. 12015                                                                                                                                    |
| H.X                                                                    | County of Registration District No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ¬ C                                                                                                                                                           |
| E E                                                                    | City of An and to man                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Local Posistrow's No. 7/                                                                                                                                      |
| X,                                                                     | Primary Registration District                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Noa                                                                                                                                                           |
| SECORD<br>EXACTLY,<br>act statemen                                     | (No. Parnell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Youfulal )                                                                                                                                                    |
| RECORD<br>EXACT                                                        | (If death occurred in a hospital or institution, give its                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | name instead of street and number.)                                                                                                                           |
| S S T                                                                  | 2. FULL NAME Sufant Peters and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                               |
| REC<br>xact                                                            | 1 11 4 2704.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | α <sub>+</sub>                                                                                                                                                |
| F F                                                                    | (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (If nonresident give city or town and State)                                                                                                                  |
| ENT B<br>stated<br>d. Exa                                              | Length of residence in city or town where death occurred. yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | How long in U. S., if of foreign birth? yrs. mos. ds.                                                                                                         |
| ING<br>A PERMANENT<br>should be state<br>rly classified. F             | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |
| Z.M.<br>d. l                                                           | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 16. DATE OF DEATH                                                                                                                                             |
| <b>교 및 결정</b>                                                          | male white or Divorced (write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Oct 14 1930                                                                                                                                                   |
|                                                                        | 5a. If married, widowed, or divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Month) (Day) (Year)                                                                                                                                          |
| E ~ 5 8                                                                | HUSBAND of<br>(or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                           |
| BIN<br>IS<br>Prop                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Still bott 19                                                                                                                                                 |
|                                                                        | 6. DATE OF BIRTH (month, day and year) Oct 14,1930                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | that I last saw h alive on 19                                                                                                                                 |
| FOR THIS ed.                                                           | 7. AGE Years Months Days If LESS than 1 day,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | and that death occurred, on the date stated above, atm.                                                                                                       |
|                                                                        | Stillborn hrs. or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | The CAUSE OF DEATH* was as follows:                                                                                                                           |
| RVE<br>INK<br>sup<br>it i                                              | 8. OCCUPATION OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Difficult olelivery                                                                                                                                           |
| & E                                                                    | <b> </b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 9 months aestation                                                                                                                                            |
| SE C SE                            | (a) Trade, profession, or particular kind of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | J. 11. 11. 11. 11. 11. 11. 11. 11. 11. 1                                                                                                                      |
| RGIN RESE<br>UNFADING<br>be carefully<br>erms, so that<br>n back of ce | (b) General nature of industry,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                               |
| GIN NFA NFA NFA NFA NFA NFA NFA NFA NFA NF                             | business, or establishment in which employed (or employer)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (duration)yrsmosds.                                                                                                                                           |
| RGI<br>UNI<br>be of                                                    | (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | contributory MalbosiTion                                                                                                                                      |
| <b>→</b> → 5                                                           | (b) Italie of eliployer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (Secondary)                                                                                                                                                   |
| _ m -                                                                  | 9. BIRTHPLACE (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (duration)yrsmosds.                                                                                                                                           |
| MLY, WITH<br>ition should<br>I'H in plain<br>instruction               | (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 18. Where was disease contracted if not at place of death?                                                                                                    |
| , T = Ē                                                                | 10. NAME OF FATHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Did an operation precede death?                                                                                                                               |
| inst N.C.                                                              | Oliver Telesson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Was there an autopsy?                                                                                                                                         |
|                                                                        | 11. BIRTHPLACE OF FATHER (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What test confirmed diagnosis?                                                                                                                                |
| PLAI<br>forma<br>DEAT<br>See                                           | (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (Signed) 6/040 G Wendle M. D.                                                                                                                                 |
|                                                                        | 11. BIRTHPLACE OF FATHER (city or town) (State or Country)  12. MALPON NAME OF MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | O. \$ 15 432 Sandbard                                                                                                                                         |
| TE of in                                                               | A 12. MAUDEN NAME OF MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (Address) Authorities of                                                                                                                                      |
| WRITE item of i                                                        | nather fact von                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT                                                                                                   |
| a die                                                                  | 13. BIRTHPLACE OF MOTHER (city or tewn) (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| ~O ~                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                               |
| lvery<br>ate C<br>very                                                 | 14. Informant OLine Filison                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 19. Place of Burial, Cremation, or Removal Date of Burial                                                                                                     |
| Every<br>state<br>is very                                              | (Address) L. II - + WFA # 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Lakenen Cemeter 10/15 1930                                                                                                                                    |
|                                                                        | The state of the s | 20. Undertaker Address                                                                                                                                        |
| <b>P. E. C.</b>                                                        | 15. Filed Oct 15, 19.30 pols allen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Gundall Co Sandfort                                                                                                                                           |
| zel                                                                    | Wegistrar Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                               |

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine. etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife. Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs. meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

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Print All Status District March 1984 And Printers the elithers endeather the word blist being frontlite the With Sales to the Language white brought are well in are cut uplithening from under may and because it had been supplied to make the best of the best The settle and now done The state of the s which the state of the s marin con se con The value of the set of the same of the same of the set Section to thinks Chi untillina CHALLE STATE OF THE STATE OF TH Thinks with that arender the beat of the child, placed in the the ale added a translation at the state was madifesting physician the same in a state of or util wife, there is allow horsebonder, predicts A survive to the calorie. A attitioner the same that which inculies 201 athir to an allege and the miles

STATE OF IDAHO NO - DEC 18 1930 DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No..... County of... Registration District No. Local Registrar's No. Primary Registration District No. EXACTLY, A PERMANENT RECORD in a hospital or institution, give its name instead of street and number.) (a) Residence. No...... (If nonresident give city or town and State) (Usual place of abode) How long in U. S., if of foreign birth? Trs. mos. Length of residence in city or town where death occurred. vrs. mos MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 16. DATE OF DEATH 5. Single, Married. Widowed. COLOR OR RACE 3. SEX or Diversed (write the word) (Day) (Month) (Year) If married, widowed, or divorced 17. I HEREBY CERTIFY, That I attended deceased from HUSBAND of (or) WIFE of 6. DATE OF BIRTH (month, day and year) If LESS than 1 day, AGE Months Days and that death occurred, on the date stated above, at hrs. or certificate The CAUSE OF DEATH\* was as follows: 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, (duration) \_\_\_\_\_yrs, \_\_\_\_mos, \_\_ business, or establishment in which employed (or employer) CONTRIBUTORY (Secondary) (c) Name of employer (duration) \_\_\_\_\_vrs. 9. BIRTHPLACE (city or town 18. Where was disease contracted (State or country) if not at place of death? .. MAME OF FATHER Did an operation precede death?.. OF DEATH Was there an autopsy? .... 11. BIRTHPLACE OF FATHER (city State or Country) important. AUSE \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE OF MOTH (State or Country) Date of Burial Place of Burial, Cremation, or Removal Informant (Address) Undertaker Address Registrar

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Do not accept a certificate of death signed only by a midwife.

PLACEBERRED ACT 3 STATE OF IDARO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH 185559Registration District No.....State File No..... (If born in hospital or institution Prim. Registration District No.....Local Registrar's No..... give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number Sex of Date of Triplet Legitiin order Child \ or other? of birth birth mate 2 (To be answered only in event of plural births) (Month (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorm? Number of child of this mother, including present birth...... (a) Born alive and now living...... Born alive but now dead.......Stillborn \_\_\_\_\_/ FULL MOTHER MAIDEN NAME .... Residence (Usual place of abode) It non-resident, give place and State If non-resident, give place and State. Color or race. Birthplace City and State or County) (City and State or County) Kaise Occupation the serv CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. Premolive (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Registrar

WHAT OF THE DEPARTMENT OF THE PROPERTY OF THE PARTY OF CHEST AND THE THE PARTY. A CHARLEST TO ME AND AND A CONTROL OF THE PARTY. Megicultus District No. Tonger Str. Prince Registration Dieselet No. THE SAME OF CHILD. the tracto stores and stilling the store state of the state of the the radiousis. district of the property of the state of the Their property was used to prevent children all Technology and the state of the marker, inciner, present inch. water went han build bet a hash were that eatly made niodE28 Native W Made beginning to the standing Rather Del percet about ting mode age and a series are a series and a series are a series and a series are 

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|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                     | RECEIVED OCT 31 1850 DEPARTMENT OF PUBL                                                                           | IC WELFARE DO NOT WRITE IN THIS SPACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| *                                                                   | BUREAU OF VITAL S                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| -3                                                                  | •11 PLACE OF DEATH -\$ '-                                                                                         | State File No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| PHYSICIÂN                                                           | County of Cassia CERTIFICATE OF                                                                                   | DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>5</b> 2                                                          |                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Ħ                                                                   | II CITY OF LOW                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| A                                                                   | Primary Registration District                                                                                     | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| . •                                                                 | (No                                                                                                               | )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <u> </u>                                                            | (If death occurred in a hospital or institution, give                                                             | e its name instead of street and number.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| ACTL<br>sified.<br>back.                                            |                                                                                                                   | <b>/</b> \                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| EXACTLY.<br>classified.                                             | 2. FULL NAME Baby Conner                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Sas C                                                               | (a) Residence. No.                                                                                                | St. (If nonresident give city or town and State.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| n Su                                                                | II (IIsual place of shode)                                                                                        | ds. How long in U. S. if of foreign birth? yrs. mo: ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>3</b> 1 3                                                        | Length of residence in city or town where death occured yes. mo.                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| D.<br>e state<br>proper                                             | PERSONAL AND STATISTICAL PARTICULARS                                                                              | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| B a g E                                                             | 3. SEX 4. COLOR OR RACE 5. Single, Married, Widowed,                                                              | 16. DATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| E 5 5                                                               | or Divorced (write the word.)                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ING<br>RECORD<br>hould be<br>may be p                               | Male White Single                                                                                                 | Sept.3 1930                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                     | 5a. If married, widowed, or divorced                                                                              | The state of the s |
| P t s ± ti                                                          | HUSBAND of                                                                                                        | 17. I HEREBY CERTIFY, That I attended deceas d from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| t BINDING<br>ANENT REC<br>AGE shoul<br>that it may<br>portant. Se   | (or) WIFE of                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 4350                                                                | 6. DATE OF BIRTH (month, day and year) Sept. 3 1930                                                               | that I last saw h alive on 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| FOR RMA                                                             |                                                                                                                   | and that death occurred, on the date stated above, at 12.30A m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| _ H & & >                                                           |                                                                                                                   | and that death occurred, on the date stated above, assume violent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| RVED F<br>S A PER<br>terms,                                         | Still Born min.                                                                                                   | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (!) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH* was as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| ter S                                                               | 8. OCCUPATION OF DECEASED                                                                                         | whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                     | (a) Trade, profession, or                                                                                         | The CAUSE OF DEATH was as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| RESERVED IIS IS A Pi fully suppli plain terms                       | particular kind of work                                                                                           | - Bead born -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| MARGIN RESE INK—THIS IS id be carefully bEATH in plain occupation   | (b) General nature of industry,                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Z E # # Z                                                           | business, or establishment in which employed (or employer)                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                     | ii                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| MARGIN DING INK—T should be car OF DEATH in                         | (c) Name of employer                                                                                              | do                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                     | 9. BIRTHPLACE (city or town)                                                                                      | (duration)mosds                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| P. F.                                                               | (State or country)                                                                                                | CONTRIBUTORY Premature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| with UNFADIN of information she distate CAUSE OF Exact statement of | 10. NAME OF FATHER                                                                                                | (Secondary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| FA                                                                  | Charles M Conner                                                                                                  | ds                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Eggg                                                                | OUGITOR W COUNTED                                                                                                 | 18. Where was disease contracted if not at place of death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| D 11 2 2                                                            | 211. BIRTHPLACE OF FATHER (city or town) La Grande                                                                | if not at place of death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Eggg                                                                | (State or Country) Oregon                                                                                         | Did an operation precede death? Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| WITH of informate state                                             | 11. BIRTHPLACE OF FATHER (city or town) Oregon  (State or Country) Oregon  12. MAIDEN NAME OF MOTHER Bessie Holst | Was there an autopsy?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                     | 12. MAIDEN NAME OF MOTHER Bessie Holst                                                                            | What test confirmed diagnosis?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 첫유절                                                                 | Brigham City                                                                                                      | (Signed) G. H. Oooker M. D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| NLY, item o                                                         | 18. BIRTHPLACE OF MOTHER (city or town) Brigham City (State or County)                                            | Sept. 19., 1930 (Address) Busy saa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| F! "                                                                |                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| PLA<br>Every                                                        | 14. C.M. Conner                                                                                                   | 19. Place of Burial, Cremation, or Removal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <u> </u>                                                            | Informant (Address) Burley Ida                                                                                    | Burley Ida Quit 4 193                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| WRITE<br>N. B.—)                                                    | (Audress)                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Æ.                                                                  | Filed 3 - Bits - 1930 The cutter                                                                                  | 20. D. E. Johnson Burley                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| ₿Z                                                                  | Filed Davidson                                                                                                    | ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

STATE OF IDAHO

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer. Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery: (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager," "Dealer," etc. without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife. Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidmic cerebrospinal meningitis"); Diptheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia"); Lobar Pneumonia: Bronchopneumonia ("pneumonia," unqualified, is indefite): Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma. Sarcoma. etc., of ...... (name origin): "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms: Measles: Whooping Cough; Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.: Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia." "Anaemia" (merely symptomatic) "Atrophy." "Collapse," "Coma." "Convulsions," "Debility." ("Congenital," "Senile," etc.), "Dropsy." "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition." "Marasmus." "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide: Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

TATE OF THE LAND Carried and a contract desired on Parish Me kein Februarien Digietal No. 2 Lough Resier, S. CHARLES THE COLUMN

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FORM V. S. No. 5-25 M. 1-19. CERTIFICATE OF DEATH State of Idaho PLACE OF DEATH BOARD OF HEALTH Bureau of Vital Statistics Registration District No. County of ... Primary Registration District No. ..... Registered No..... City of Jan If death occurred in a hos-If death occurs away from usual residence, give facts pital, institution or camp, give its NAME instead of called for under special instreet and number. formation. PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH 3. SEX 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-OWED OR DIVORCED 16. DATE OF DEATH the word.) 6. DATE OF BIRTH (Month) (Day) (Year) I HEREBY CERTIFY, That I attended deceased from (Month) (Year) 7. AGE IF LESS than 1 day how many hrs. M — THIS IS only be stated E OCCUPATION and that death occurred on the date stated above. at ... A.M. or.....min.? 8. OCCUPATION The CAUSE OF DEATH\* was as follows: (a) Trade, profession or particular kind of work.... (b) General nature of industry, business or establishment in which employed (or employer)..... (Duration) Yrs. mos. 9. BIRTHPLACE Contributory (State or Country) (Secondary) 10. NAME OF (Duration) FATHER 11. BIRTHPLACE OF FATHER (Address) .... (State or Country) \*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal. 12. MAIDEN NAME OF MOTHER 18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.) 13. BIRTHPLACE OF MOTHER At place In the mos. days. State vrs. mos. of death (State or Country) Where was disease contracted 14. THE ABOVE IS TRUE TO THE REST OF MY KNOWLEDGE if not at place of death?.... Former or (Informant) usual residence 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 10-25 1030 15. 20. UNDERTAKER Local Registrar SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

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etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUER-PERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train -accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis. tetanus) may be stated under the head of "Contributory."

PLACE SPECIFIE \_D NOV 15 1930 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of KooTana BUREAU OF VITAL STATISTICS ('neur d' CERTIFICATE OF BIRTH Registration District No. / 050 State File No. RETURN (If born in hospital or institution Prim. Registration District No. 30. Local Registrar's No. 4 give name.) FULL NAME OF CHILD ..... (If stillborn, substitute the word "Stillbirth" for name of shild) Number Twin Legiti- 4 Date d in order Sex of~ Triplet birth mate? or other? Child (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth (a) Born alive and now living Born alive but now dead O Stillborn FULL FATHER MAIDEN Residence (Usual place of abode) CDA Residence (Usual place of abode) CDA If non-resident, give place and State It non-resident, give place and State Color or rade... Birthplace . and State or County) Occupation .... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE I hereby certify that I attended the birth of this child, who was Stillborn PLAIN on the date above stated. (Signature) \*Where there was no attending physician? or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DEP SEE SECTION OF THE EARLY DESCRIPTION OF THE PERSON OF THE CHRISTICATE OF PUBLICA The state of the s Print Registrates Maister No. THE SECOND (Marie and to the all the wall supplied to the training the There is a second to the control of property was used to provent delinings Notice and stillbord L. stillbord Then style but now dead, PATER NAME OF THE PARTY About the said from the said and the said an the contract of the part of th Co les or 1300 Cours of the Act of the Pirtheles. to contract the contract of th County on the State On County Decopation The section Commence Commence CHRITICIATE OF ATTENUING PHYSICIAN OR MIDWISS. thereby middly that I started the birth of this child, who was Stillburn on the date above stated. street there was no attending physician (Charles of the Control or inherity than the father, bouseholder. ere, should state this return. A stillborn drift is one that seither breathes nor shows other evidence of life after birth.

| PERMANENT RECORD<br>EFIURN must be made for<br>stated. | City of St.  No. St.  Registration Dist  (If born in hospital or institution give name.)  FULL NAME OF CHILD.  (If stillborn, sub                                                                                                           | on District No. 2. Local Registrar's No                          |
|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| TE R<br>birth                                          | Sex of Child Male Triplet and in order of birth (To be answered only in event of plural bi                                                                                                                                                  | Legiti- mate? 2 Date of Aug 1936 (Month) (Day) (Year)            |
| ARA7                                                   | What prophylactic was used to prevent Ophthalmia Neo                                                                                                                                                                                        | natorum 7                                                        |
| SEPA<br>order                                          | Number of child of this mother, including present birth                                                                                                                                                                                     | (a) Born alive and now living One                                |
| 2 5                                                    | Born alive but now dead                                                                                                                                                                                                                     | Stillborn                                                        |
| irth<br>sch, i                                         | FULL PAS a Cure                                                                                                                                                                                                                             | MAIDEN Rus Ty                                                    |
| 6 P C                                                  | Residence (Usual place of abode) Bakes                                                                                                                                                                                                      | Residence (Usual place of abode)                                 |
| FAD<br>child<br>aber                                   | If nonresident, give place and State                                                                                                                                                                                                        | If nonresident, give place and State                             |
| Z 🖁                                                    | Color or race Age at last Birthday (Years)                                                                                                                                                                                                  | Color or race Age at last Birthday (Years)                       |
|                                                        | Birthplace (City/and State or Country)                                                                                                                                                                                                      | Birthplace (City and State or Country)                           |
| VITH<br>than<br>d the                                  | Occupation (Chyand State of Country)                                                                                                                                                                                                        | Occupation /                                                     |
|                                                        | CERTIFICATE OF ATTENDIN                                                                                                                                                                                                                     | G PHYSICIAN OR MIDWIFE.                                          |
| PLAINLY V                                              | I hereby certify that I attended the birth of this chi<br>on the date above stated.  (Sign                                                                                                                                                  | ature)  Bern alive at M.  M.  M.                                 |
| WRITE PLA<br>N. B.—In case                             | *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.  **Address:  Address:  Filed. | (Physician or midwife)  SS Alum  19.3.0 Clast Magney  Registrar. |

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| A-                                                     |                                                                                                                  | RECEIVED SEP 1 5 1930                                                    | STATE OF IDA                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                 |
|--------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| PHYSICIANS<br>of OCCUPA-                               |                                                                                                                  | •                                                                        | DEPARTMENT OF PUBLI<br>BUREAU OF VITAL ST |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | DO NOT WRITE IN THIS SPACE                                                      |
|                                                        |                                                                                                                  | - PLACE OF DEATH                                                         | CERTIFICATE OF                            | ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | State File No.                                                                  |
| H K                                                    | Co                                                                                                               | unty of Sujulia                                                          | gistration District No                    | W I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | State File 1(0                                                                  |
| = 1                                                    | Ci                                                                                                               | v of a to A do I a                                                       | -                                         | 14 11 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Local Registrar's No                                                            |
| L'X,                                                   |                                                                                                                  |                                                                          | mary Registration District                | 110                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                 |
| RECORD   EXACTLY,     Kact statement                   |                                                                                                                  | (N) (If death occurred in                                                | o.<br>a hospital or institution, give its | name instead of street and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | number.)                                                                        |
|                                                        | 2.                                                                                                               | FULL NAME                                                                | Moirlh                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>~</b>                                                                        |
| R S C                                                  |                                                                                                                  | (a) Residence. No                                                        |                                           | St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                 |
| ENT<br>stated<br>d. Ex                                 | L                                                                                                                | (Usual place of abode) ength of residence in city or town where death or |                                           | (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | If nonresident give city or town and State) of foreign birth? yrs. mos. ds.     |
| DING A PERMANENT should be state erly classified. E    |                                                                                                                  |                                                                          |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | AL CERTIFICATE OF DEATH                                                         |
| GRMANE                                                 |                                                                                                                  | PERSONAL AND STATISTICAL E  SEX 4. COLOR, OR RACE 5                      | Single, Married, Widowed,                 | 16. DATE OF DEAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                 |
| 등등등                                                    | ٠.                                                                                                               | 1110, 410                                                                | r Divorced (write the word)               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 2 1/th 1000                                                                     |
| PER Should cla                                         |                                                                                                                  | If married widowed or divorced                                           |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (Month) (Day) (Year)                                                            |
| BINDIN<br>IS A P<br>AGE sho<br>properly                | "                                                                                                                | . If married, widowed, or divorced<br>HUSBAND of<br>(or) WIFE of         |                                           | 17. I HEREBY CERT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | IFY, That I attended deceased from                                              |
| D FOR PHES ate.                                        |                                                                                                                  |                                                                          |                                           | - May 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | , 19 <del>30</del> , to ling // , 1930                                          |
|                                                        |                                                                                                                  | DATE OF BIRTH (month, day and year)  AGE Years Months Days               | If LESS than 1 day,                       | that I last saw h                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1. 0                                                                            |
|                                                        |                                                                                                                  |                                                                          | hrs. or                                   | ) i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | m.                                                                              |
|                                                        | 8. OCCUPATION OF DECEASED /                                                                                      |                                                                          | The CAUSE OF DEATH* was as follows:       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                 |
| SER<br>NG II<br>IIIy s<br>that                         |                                                                                                                  |                                                                          |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                 |
| は 乙 官 平 。 「                                            |                                                                                                                  | (a) Trade, profession, or<br>particular kind of work                     |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                 |
|                                                        | (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer |                                                                          |                                           | M. of the control of | (daration)rsmosds.                                                              |
| MAKGIN TH UNFA III be ca in terms, n on back           |                                                                                                                  |                                                                          |                                           | CONTRIBUTORY ATT CHANGE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                 |
| a 1                                                    |                                                                                                                  | (c) Name of employer                                                     | 0 0 1 0 .                                 | (Secondary)  (duration) yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                 |
| MANTER Should plain ction                              | 9. BIRTHPLACE (city or town) Bake Glake                                                                          |                                                                          |                                           | 18. Where was disease contracted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                 |
| NLY, WITI<br>tion shoul<br>I'H in plair<br>instruction |                                                                                                                  |                                                                          |                                           | if not at place of d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | leath?                                                                          |
| NLY,<br>ation<br>FH in                                 |                                                                                                                  | 10. NAME OF FATHER CASA                                                  | DWENS                                     | Did an operation prece                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | de death ? Date or                                                              |
| PLAINLY<br>nformation<br>DEATH                         | က္က                                                                                                              | 11. BIRTHPLACE OF FATHER (city or town                                   | 1)                                        | Was there an autopsy What test confirmed di                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                 |
| PLAID<br>nforma<br>DEAT<br>See                         | ENE                                                                                                              | (State or Country)                                                       | mina                                      | (Signed) / Johnship M.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                 |
| re j<br>or<br>int.                                     | PARENTS                                                                                                          | 12. MAIDEN NAME OF MOTHERA .                                             | 7                                         | any 10 191                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 30 (Address) Salmon                                                             |
|                                                        | "                                                                                                                | This                                                                     | JM                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                 |
| WRI<br>y item o<br>CAUSE<br>y importa                  |                                                                                                                  | 18. BIRTHPLACE OF MOTHER (sity or town (State or Country)                | n)                                        | CAUSES, state (1) M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CAUSING DEATH, or in deaths from VIOLENT<br>IEANS AND NATURE OF INJURY, and (2) |
| ~O ~                                                   |                                                                                                                  | O W                                                                      | me V                                      | I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | , SUICIDAL, or HOMICIDAL.                                                       |
| wery                                                   | 14                                                                                                               | Informant Will, TM,                                                      |                                           | 19. Place of Burial, Co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | remation, or Removal Date of Burial                                             |
| Ever<br>state<br>is ver                                |                                                                                                                  | (Address)                                                                | Saker Ida                                 | Value (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | unely 92                                                                        |
| S. E. E.                                               | 15                                                                                                               | Filed 9/10 1930 Ola                                                      | - Bellama (                               | 20. Undertaker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Address Da                                                                      |
| ZŽĚ                                                    |                                                                                                                  |                                                                          | Registrar                                 | 170                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ever Jourse Van                                                                 |

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uraemia," "Weakness," etc., when a definite disease can be assentiated as the cause. disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or

HOMICIDAL, or as probably such, if impossible to de-

termine definitely. Examples: Accidental drowning;

struck by railway train-accident: Revolver wound of head-homicide; Poisoned by carbolic acid-probably sui-

cide. The nature of the injury, as fractured skull, and con-

sequences (e. g. sepsis, tetanus) may be stated under the

spinal fever (the only definite synonym is "Epidemic

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

head of "Contributory."

| S IS A PERMANENT RECORD<br>IPARATE RETURN must be made<br>order of birth stated. | County of PECFIVED NOV 6 1930 EPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS  CERTIFICATE OF BIRTH 18574!  No. St. CERTIFICATE OF BIRTH 18574!  Winchester Registration District No. Scate File No. State File N |
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| ch, in                                                                           | Number of child of this mother, including present birth. Mone (a) Born alive and now living. The Born alive but now dead. Stillborn Stillborn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| NG INK—<br>d at birth<br>er of each                                              | FULL Chas W. FATHER MAIDENMIS Laura Creptis  Residence (Usual place of abode) Winchester, Idaho. Residence (Usual place of abode) Winchester, Idaho.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| UNFADING<br>one child a<br>he number                                             | If non-resident, give place and State  Color or race. While Age at last Birthday. Color or race. While Age at last Birthday. (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| WITH<br>re than<br>r and th                                                      | Occupation  |
| PLAINLY Case of more for each                                                    | I Mereby certify that I attended the birth of this child, who was Stillborn at Signature)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| WRITE<br>N. B.—In                                                                | *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.  Address   Filed   Registr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

PURPLIC OF VICE STATESTICS Resistantion District Vo. 2. State Pile 'S Print. Rectsilation District Manager Local Montages, No. ( of the man not bericht work with the name of the to The state of the s The property was used to present Ophthal da Vennagrung status of court of intermenter, notioner present with most int. Born attendand now I ving... inert was the world with Bridger (Linut place at shade , second The state of the s It nun-reisenst, mier place at d 3h to Superindent, and despendent of the TRAIL OF STREET STREET, STREET OF THE STREET Age at last Birthilay Union in state and state or court of Cympoly to the but the CHRECTO AND ALLEMENTS BEARING OF MERIES. depend could that I parended the birth of this width, who was Stillborn on the that where stated Bikanniur | Later Committee the pare was no attenuing physician (Physician or originally) permitted then the father, householder, more make the rotors A cilling one entire the settler breather not

| RECORD<br>EXACTLY, PHYSICIANS<br>tact statement of OCÇUPA                                                                                                                                                 | PLACE OF DEATH  County of City of County of City of City of County of City of | DO NOT WRITE IN THIS SPACE STATE STATE  No. 2/2/2  Local Registrar's No. 2/2/2  Local Registrary No. 2/2/2 |
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| MANENT R<br>be stated<br>ssified. Exa                                                                                                                                                                     | (a) Residence. No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | St.  (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.  MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  Oct. 25                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| IVED FOR BINDING INK—THIS IS A PER supplied. AGE should it may be properly clarificate.                                                                                                                   | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of  6. DATE OF BIRTH (month, day and year) Oct. 25, 1930  7. AGE Years Months Days If LESS than 1 day, hrs. or min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (Month) (Day) (Year)  17. I HEREBY CERTIFY, That I attended deceased from  19. 19. 19. 19. 19. 19. 19. 19. 19. 19.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| MARGIN RESERV) WRITE PLAINLY, WITH UNFADING IN —Every item of information should be carefully su is state CAUSE OF DEATH in plain terms, so that it is very important. See instruction on back of certifi | 8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (duration) yrs. mos. ds.  CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                           | 9. BIRTHPLACE (city or town) William (State or country)  10. NAME OF FATHER Chas. W. Standard (State or Country)  11. BIRTHPLACE OF FATHER (city or town) Surfly Jake (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 18. Where was disease contracted if not at place of death?  Did an operation precede death?  Was there an autopsy?  What test confirmed diagnosis?  (Signed)  (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                           | 12. MAIDEN NAME OF MOTHER SAUVA Grentles  18. BIRTHPLACE OF MOTHER (city or town) Association (State or Country)  14. Informant Char. W. Hyntler  (Address) Winehester, Ida.  15. Filed 1930 RG Duresu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  19. Place of Burial, Cremation, or Beneval Date of Burial Oct. 25 193  20. Undertaker Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| N. B.                                                                                                                                                                                                     | Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman." "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inantion," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning;

spinal fever (the only definite synonym is "Epidemic

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

struck by railway train-accident: Revolver wound of

head-homicide; Poisoned by carbolic acid-probably sui-

cide. The nature of the injury, as fractured skull, and con-

sequences (e. g. sepsis, tetanus) may be stated under the

Do not accept a certificate of death signed only by a

midwife.

head of "Contributory."

| What prophylactic was used to prevent Ophthalmia Neonatorum?  Number of child of this mother, including present birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | HIS IS A PERMANENT RECORD SEPARATE RETURN must be made in order of birth stated. | No. St.  Registration Dis  (If born in hospital or institution give name.)  FULL NAME OF CHILD  Twin Triplet or other?  (To be answered only in event of plural births.) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |   |
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| Born alive but now dead.  FATHER FULL NAME  FOULL NAME  Stillborn  FATHER FULL MAIDEN NAME  Residence (Usual place of abode)  It non-resident, give place and State  Color or race.  Color or  | 3 B 6                                                                            |                                                                                                                                                                          | The state of the s | 5 |
| Residence (Usual place of abode)  Reside |                                                                                  |                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |   |
| Residence (Usual place of abode)  Reside | 743                                                                              |                                                                                                                                                                          | Stillborn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |   |
| Color or race (Years)  Birthplace (City and State or County) Occupation  CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE  I hereby certify that I attended the birth of this child, who was Stillborn at On the date above stated.  (Signature)  *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life attention.  Color or race (City and State or County) Occupation  O | 2.0                                                                              | A                                                                                                                                                                        | MATDEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |   |
| Color or race (Years)  Birthplace (City and State or County) Occupation  CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE  I hereby certify that I attended the birth of this child, who was Stillborn at On the date above stated.  (Signature)  *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life attention.  Color or race (City and State or County) Occupation  O | P P P                                                                            | Residence (Usual place of abode).                                                                                                                                        | Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |   |
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| Birthplace (City and State or County) Occupation  CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE  I hereby certify that I attended the birth of this child, who was Stillborn at On the date above stated.  (Signature)  *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life attention by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                  |                                                                                                                                                                          | Color or race that Age at last Birthday 40                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |   |
| Certificate of Attending Physician or midwife, the the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after high.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 255                                                                              | Birthplace were Mak                                                                                                                                                      | Birthplace (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |   |
| CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE  I hereby certify that I attended the birth of this child, who was Stillborn at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                  | (City and State or County)                                                                                                                                               | (City and State or County)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |   |
| I hereby certify that I attended the birth of this child, who was Stillborn at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | R n                                                                              |                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |   |
| I hereby certify that I attended the birth of this child, who was Stillborn at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ू हुन                                                                            | CERTIFICATE OF ATTENDIN                                                                                                                                                  | · · · · · · · · · · · · · · · · · · ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |   |
| *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after high.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2 8 8 E                                                                          | <b></b>                                                                                                                                                                  | ] =                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |   |
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| or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after high                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                  |                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |   |
| etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after high                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 25                                                                               |                                                                                                                                                                          | ***************************************                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |   |
| shows other syldence of life after birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                  |                                                                                                                                                                          | (Physician or midwife)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |   |
| shows other syldence of life after birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | E E                                                                              |                                                                                                                                                                          | dress leutest                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |   |
| Filed 1900 All Blussel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                  | shows other evidence of life after high                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                  | File                                                                                                                                                                     | ed // J 1900 CM Blussel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |   |

Registration District No. activitieff de larigeof at medit Princ. Registration District No. .... Local Machiner \_QIBO TO BELL (Ne stillborn, sebatitute the werd "Acilorein" for neme at shill) Tedenti bas toffer. digital to i The server or only in event of plant ! with Atomata: The grandstatte and upon to provent Ordeballala Noonstorum TATHER LEFT MAIDEN MAN BELLEVILLE TO THE PROPERTY OF THE PROPERTY Mandatage of a state o If and resident, give plays, and State. Color or race and a last last Birthey Color or race and have at last Birthey Siribpinos (Cit) and Siate or Conney) telle and dista or County) Occupation CENTIFICACE OF ATTEMBING PRYSICIAN OR MIDWIES. besoin cortify that I attended the birth of this child, who was idealibers if at on the diffic allowe stated. (Skuature) .... There there was no attending physician) or midwife, then the father, householder. (Physician or midwiffs) effer should make this return. A still born with is one that neither breather nor Address theme other evidence of life after hirth.

| uld<br>i is                            | 1. PLACE OF DEATH ON 6 1930 CERTIFICATE O                                                                |                                                                                                     |                                                                                             |  |
|----------------------------------------|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--|
| sho<br>TON                             | County of Musical Registration District No                                                               |                                                                                                     | 72498                                                                                       |  |
| ANS<br>PAT                             | City of Person Primary Registration Distri                                                               | Local Registrar's                                                                                   |                                                                                             |  |
| LD PHYSICIANS should of OCCUPATION is  | If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME | If do pita give                                                                                     | eath occurred in a hos-<br>l, institution or camp,<br>its NAME instead of<br>et and number. |  |
| ore<br>ore                             |                                                                                                          | MEDICAL CERTIFICATE OF                                                                              |                                                                                             |  |
| T RECORD<br>XACTLY, PI<br>statement o  | PERSONAL AND STATISTICAL PARTICULARS  8. SEX   4. COLOR OR BACE   5. SINGLE, MARRIED, WID-               | medical certificate of                                                                              | DEATH OF                                                                                    |  |
| T J<br>XAC<br>stat                     | OWED OR DIVORCED                                                                                         | 16. DATE OF DEATH                                                                                   | //                                                                                          |  |
| [ANENated E<br>Exact                   | He white Sugle (Write the word)                                                                          | (Month)                                                                                             | Day) (Year)                                                                                 |  |
| MAN<br>tated<br>Exs                    | 6. DATE OF BIRTH                                                                                         | 17. I HEREBY CERTIFY, That I at                                                                     | tended deceased from                                                                        |  |
| SEE<br>SEE                             | Oct 16 1/30                                                                                              | Oct 16 1930, to                                                                                     |                                                                                             |  |
| SINDEN<br>IS A I<br>should<br>classifi | (Month) (Day) (Year) 7. AGE   IF LESS than 1                                                             | that I last saw have alive on Oct                                                                   | 16 1950,                                                                                    |  |
| BINDI<br>IS A<br>should<br>classif     | day how many                                                                                             | and that death occurred on the date state                                                           |                                                                                             |  |
| OR CEE                                 | O Yrs O Mos O ds O hrs. or min.?                                                                         | The CAUSE OF DEATH was as follows:                                                                  |                                                                                             |  |
| D FOR                                  | 8. OCCUPATION                                                                                            | Stillbon                                                                                            |                                                                                             |  |
| <b>□ □ □ □</b>                         | (a) Trade, profession or particular kind of work.                                                        |                                                                                                     |                                                                                             |  |
|                                        | (b) General nature of in-                                                                                |                                                                                                     |                                                                                             |  |
| Cate H                                 | dustry, business or estab-<br>lishment in which employ-                                                  | Contributory Assukusso                                                                              |                                                                                             |  |
| RGIN<br>UNFA<br>carefu<br>that i       | ed (or employer)                                                                                         | (Secondary)                                                                                         |                                                                                             |  |
| MARCH<br>Be UI<br>So the               | (State or Country) Lugar Idalio                                                                          | (Duration)yrs                                                                                       | mosds.                                                                                      |  |
|                                        | 10. NAME OF Father                                                                                       | (Signed)                                                                                            |                                                                                             |  |
| t, WIT<br>should<br>terms,<br>n back   | 11. BIRTHPLACE                                                                                           | 11-41930 (Address) Rufest.                                                                          | in deaths from Violent                                                                      |  |
| 7 7 6                                  | OF FATHER (State or Country) Mephic Male                                                                 | *State the Disease Causing Death; or Causes, state (1) Means of Injury; and (Suicidal or Homicidal. | 2) whether Accidental,                                                                      |  |
| 7 60 13                                | 12. MAIDEN NAME                                                                                          | 18. LENGTH OF RESIDENCE (For E                                                                      | Iospitals. Institutions.                                                                    |  |
| E PL<br>form<br>H in                   | OF MOTHER Stadys Selecule  18. BIRTHPLACE                                                                | Transients or Recent Residents.)                                                                    |                                                                                             |  |
|                                        | OF MOTHER (State or Country) the file, relate,                                                           | of deathyrsmosdays. State.                                                                          | yrs,mosds.                                                                                  |  |
| WR of See                              | 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE                                                        | Where was disease contracted if not at place of death?                                              |                                                                                             |  |
| B.—Every item of the CAUSE OF D        | (Informant) Trancis riple                                                                                | Former or usual residence                                                                           |                                                                                             |  |
| USI                                    | (Address) Rupert - Idaho                                                                                 | 19. PLACE OF BURIAL OR REMOVAL                                                                      | DATE OF BURIAL                                                                              |  |
| E CA                                   | 15.                                                                                                      |                                                                                                     | 19                                                                                          |  |
| Y. B.<br>tate<br>'ery                  | Filed Nov. 4 1930 800 Electronic Local Registrar                                                         | 20. UNDERTAKER                                                                                      | ADDRESS                                                                                     |  |
| F4 80 P                                | Local Registrar                                                                                          |                                                                                                     |                                                                                             |  |

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery: (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager." "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia: Bronchopneumonia ("Pneumonia." unqualified, is indefinite): Tuberculosis of lungs. meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of ......(name origin; "Cancer' is less definite; avoid use of "Tumor" for malignant neoplasms: Measles: Whooping cough: Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.: Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congental." "Senile." etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock." "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUER-PERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train -accident: Revolver wound of head-homicide: Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis. tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS City CERTIFICATE OF BIRTH Registration District No. 7693 State File No. (If born in hospital or institution Prim. Registration District No. 1009 Local Registrar's No. give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of child) Legitty Chirth Number Sex at Triplet and d in order Child. or other? of birth (To be answered only in event of plural births) (Month) (Day) What prophylactic was used to prevent Ophthalmia Neonatorum? FULL MOTHER FULL MAIDEN Residence (Usual place of abode) It non-resident, give place and State If non-resident, give place and State \_\_\_\_\_ Color or race Birthplace S and State or County) (City and State or County) CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE I hereby certify that I attended the birth of this child, who was Stillbown on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, ysician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth.

STACKALES Action theory of the Contract willed the design of the second to the secon the second to regular broom our inclined is incoming the Assential And Assential Assential Assential Assential Assentia The second secon Legities (Total agent at coon in the color (affects) What presbytheth was paid to mercut Oputhalais Techarorung? to wive but now death. (1) Marile uce . I well olsow water if con mideat, wire placeand topic, and Stohn de trees and the fact the at the te sin 3 base (H) Occupation Land Contraction molleum w CENTERCATE OF ATTENDING PICTEDIAN OR HIDWIPED I hereby cortify that I attended the pluth of this child, who was builborn is for the state when son no Stansiure . \* Wirre there was no nigerfiles physician o midwife, then the father, householder, (Pilyabita 10: catalatiff) reich, should make this court. A sidficen cities one that neither breathes nor sumve owier exidence of Hie after bight.

| <b>a</b>                              | PLACE PETE NOV 8 1930 DEPA                                                           | STATE OF IDAHO                                   |
|---------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------|
| RD<br>e f                             | County of ( Mella)                                                                   | RTMENT OF PUBLIC WELFARE                         |
| RECOR<br>be made                      | City of Walack                                                                       | JREAU OF VITAL STATISTICS                        |
| RECO<br>be mad                        | N- St                                                                                | CERTIFICATE OF BIRTH                             |
|                                       | Community Hospitakegistration Dist                                                   | rict No. 26 State File No. 185819                |
| PERMANENT<br>EFFURN must<br>1 stated. | /74 1 1. 1 1. 1. 1. 1. 1. 1. 1. 1                                                    | 7 4/00                                           |
|                                       | give name.) Prim. Registration                                                       | n District No. 20 OCLocal Registrar's No. 24     |
| E E E                                 | FULL NAME OF CHILD                                                                   | sew tark -                                       |
| PERMAN<br>RETURN<br>h stated.         |                                                                                      | stitute the word "Stillbirth" for name of child) |
| 교육                                    | Sex of Triplet and Number in order                                                   | Legiti- Date of birth 19 30                      |
| A E I E                               | Child (or other?) (of birth                                                          |                                                  |
| SE To                                 | What prophylactic was used to prevent Ophthalmia Neo                                 | natorum/ Angrand                                 |
| F A                                   |                                                                                      | (a) Born alive and now living                    |
| SEP ord                               | Born alive but now dead                                                              | Stillborn.                                       |
| N a H                                 | C FATHER 1                                                                           | FULL MOTHER                                      |
| birth<br>each,                        | NAME GLOS Z Mard fr.                                                                 | NAME XIIIA Jores                                 |
| ا و <u>م</u>                          | Residence (Usual place of abode) Malhad                                              | Residence (Usual place of abode Malas.           |
| C a d                                 |                                                                                      | If nonresident, give place and State             |
| hile                                  | If nonresident, give place and State.                                                | 26                                               |
| UNF<br>ne ch<br>numl                  | Color or race What Age at last Birthday (Years)                                      | Wars)                                            |
|                                       | Birthplace (City and State or Country)                                               | Birthplace (Ofty and State or Country)           |
| WITH<br>than                          | Occupation as not                                                                    | Occupation Attustwale                            |
| w w                                   | CERTIFICATE OF ATTENDIN                                                              | IG PHYSICIAN OR MIDWIFE*                         |
| P og q                                | I hereby certify that I attended the birth of this ch                                |                                                  |
|                                       | on the date above stated.                                                            | lature) V. V. Jaset                              |
| E E                                   | lgia)                                                                                | lature)                                          |
| PIL/                                  | *Where there was no attending physician                                              | (Physician or midwife)                           |
| TE                                    | or midwife, then the father, householder, etc., should make this return. A stillborn | -maket Class                                     |
| WRITE<br>B.—In                        | child is one that neither breathes nor                                               | ess // alan caus                                 |
| × ×                                   | shows other evidence of life after birth.   Filed                                    |                                                  |
| <b>F</b> 4                            | <b>1</b> -                                                                           | Registrar.                                       |

t e # 1/ -••

| REC. NOV 8 1930 STATE OF IDA                                                                         | .HO                                                                                                                                                           |
|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| DEPARTMENT OF PUBL                                                                                   | •                                                                                                                                                             |
| PLACE OF DEATH BUREAU OF VITAL S'                                                                    | fatisfics $72522$                                                                                                                                             |
| County of Queeda CERTIFICATE OF                                                                      | DEATH, State File No                                                                                                                                          |
| Registration District No.                                                                            | 26                                                                                                                                                            |
| City of Primary Registration District                                                                |                                                                                                                                                               |
| (If death occurred in a hospital or institution, give its                                            | · V ·                                                                                                                                                         |
| (a) Residence. No. Zurly Jak<br>(Usual place of abode)                                               | St. (If nonresident give city or town and State)                                                                                                              |
| Length of residence in city or town where death occurred. yrs. mos. ds                               | . How long in U. S., if of foreign birth? yrs. mos. ds.                                                                                                       |
| PERSONAL AND STATISTICAL PARTICULARS                                                                 | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |
| 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)                    | 16. DATE OF DEATH  Oct - 2/ 19-24                                                                                                                             |
| 5a. If married, widowed, or divorced                                                                 | (Month) (Day) (Year)                                                                                                                                          |
| HUSBAND of (or) WIFE of                                                                              | 17 I HEBEBY CERTIFY, That I attended deceased from                                                                                                            |
| 6. DATE OF BIRTH (month, day and year) Od. 21-30                                                     | that I last saw h alive on 19                                                                                                                                 |
| 7. AGE Years Months Days If LESS than 1 day,                                                         | and that death occurred, on the date stated above, at                                                                                                         |
| M. I Burn hrs. or                                                                                    | The CAUSE OF DEATH* was as follows:                                                                                                                           |
| Min.                                                                                                 | L All                                                                                                                                                         |
| 8. OCCUPATION OF DECEASED                                                                            | Milson.                                                                                                                                                       |
| (a) Trade, profession, or — particular kind of work                                                  |                                                                                                                                                               |
| (b) General nature of industry, business, or establishment in which employed (or employer)           | (duration)yrsmosds.                                                                                                                                           |
| (c) Name of employer                                                                                 | CONTRIBUTORY (Secondary)                                                                                                                                      |
| a DIRTHRIAGE (site on town) Malad                                                                    | (duration)yrsmosds.                                                                                                                                           |
| 9. BIRTHPLACE (city or town) (State or country)                                                      | 18. Where was disease contracted if not at place of death?                                                                                                    |
| 10. NAME OF FATHER 2                                                                                 | Did an operation precede death?                                                                                                                               |
| uss & ward                                                                                           | Was there an autopsy? 2.0                                                                                                                                     |
| W ALL DEPOSITE ACT OF GLOVER ALL                                                                     | What test confirmed diagnosis?                                                                                                                                |
| 11. BIRTHPLACE OF FATHER (city or town) (State or Country)                                           |                                                                                                                                                               |
| 11. BIRTHPLACE OF FATHER (city or town) (State or Country)  12. MAIDEN NAME OF MOTHER (City or town) | (Signed), M. D.                                                                                                                                               |
| 12. MAIDEN NAME OF MOTHER Selila Trues                                                               | (Address) Analad Y 14                                                                                                                                         |
| 13. BIRTHPLACE OF MOTHER (city or town) (State or Country)                                           | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| 14. Informant Jers & Ward                                                                            | 19. Place of Burial, Cremation, or Removal  Date of Burial                                                                                                    |
| (Address) I Maked Oda,                                                                               |                                                                                                                                                               |
| 15. Filed 10-51, 1930. 2.10.10s.us Registrar                                                         | 20. Undertaker Land Staked Class                                                                                                                              |
| Kegistrar                                                                                            |                                                                                                                                                               |

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and t death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in month

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"Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH,

state occupation at beginning of illness. If retired from

business that fact may be indicated thus: Farmer (retired

6 yrs.) For persons who have no occupation whatever,

second statement. Never return "Laborer," "Foreman,"

write None. STATEMENT OF CAUSE OF DEATH-Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-DUTY OF LOCAL REGISTRARS-Mail all death certicates filed with you to the State Registrar on or before the

for your local record. Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated

fifth of the following month; keeping a copy of same

Registrars should be careful to see that the medical

unknown.

cerebrospinal meningitis"); Diphtheria (avoid use "Croup"); Typhoid fever (never report "Typhoid Pne monia"); Lobar pneumonia; Bronchopneumonia ("Pne monia." unqualified, is indefinite); Tuberculosis of lung

spinal fever (the only definite synonym is "Dpiden

meninges, peritoneum, etc., Carcinoma, Carcoma, etc., (name origin; "Cancer" is less definite; avo use of "Tumor" for malignant neoplasms; Measle Whooping cough: Chronic valvular heart disease; Chro interstitial nephritis, etc. The contributory (secondary

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itis," etc. all diseases resulting from childbirth or misc; riage. State cause for which surgical operation was a dertaken. For VIOLENT DEATHS, state MEANS ( INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as probably such, if impossible to termine definitely. Examples: Accidental drowning struck by railway train-accident; Revolver wound

the deceased and it is probable that death was due to a

"Shock," "Uraemia," "Weakness," etc., when a defin

disease can be ascertained as the cause. Always quali

as "PUERPERAL septicemia," "PUERPERAL perito

head-homicide; Poisoned by carbolic acid-probably s cide. The nature of the injury, as fractured skull, and co sequences (e. g. sepsis, tetanus) may be stated under head of "Contributory." statement of death is supplied. If no physician attender

lawful or suspicious means, the case should be referred the Coroner for investigation and statement of the cau of death; other deaths than above without medical atter ance should be referred to the Health Officer (if a phy cian), but when there is no such health officer, and or in such cases, the local registrar may make the return up the information of relatives or friends of the deceas having adequate knowledge of the facts.

Do not accept a certificate of death signed only by

midwife.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS City CERTIFICATE OF BIRTH No. 85829 Registration District No. (If born in hospital or institution nn. Registration District No. 26 69 Local Registrar's No. // give name.) FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Sex of Legi Triplet in order birth Child or other? (Day) (To be answered only in event of plural births) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth (a) Born alive and now living Stillborn. Born alive but now des FULL MAIDE Residence (Usual place of abode) Residence (Unital place of abode) If nonresident, gift If nonresident, give place at last Birthday. Color or rac (Years) Birthplace Birthplace and State or Kountry) Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE more I hereby certify that I attended the birth of this child, who was on the date above stated. 6 (Signature) \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Registrar.

MARKET INTERPORTED SHERRIE OF BURTIE but a discount or matitude inthe Ma. C. C. Land Roghtrage No. 2 ..... CHED STREET OF CRIED if sail ora aubelliere to a controlled to the name of south to state Eccitiunity? Birth Munich respirated was used to access Onbehalula Rematerine remose of the first of the man property property british and the state of the second british and the street british and the second britis an alies hus now dead. Pridence Unal place of abote ...... ll aco-recident start starte and the second state bree rough my new transport Color of the second of last Birthday tone of the strange o Things to one State Hilly and the confidence

forests certify that is strended the birth of this child, who can States at at the chief where wered.

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or indeedle, then the father, householder, the should make this return. A stillbern should make that distinct breathes not state that distinct breathes not show collections of the after that

fewere flowe was no attending physicians

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STATE OF IDAHO Q2DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH State File No...... Registration District No. 37 County of Local Registrar's No....172 Exact statement Primary Registration District No. five its name instead instead of street and number.) hospital of institution (If death occurred in 2. FULL NAME. RECORD (a) Residence (If nonresident give city or town and State) (Usual place of abode) ds. How long in U. S., if of foreign birth? mos. Length of residence in city or town where death occurred MEDICAL CERTIFICATE OF DEATH classified PERSONAL AND STATISTICAL PARTICULARS 5 Single, Married, Widowed, 16 DATE OF DEATH 3 SEX 4 COLOR OR RACE or Divorced (write the word) (Day) (Month) 5a If married, widowed, or divorced I HEREBY CERTIFY, That I attended deceased from HUSBAND of 17 (or) WIFE of that I last saw h. 8 DATE OF BIRTH (month, day and year) and that death occurred, on the date stated above, at 7 AGE Years Months Days If LESS than sapplied. day, ..... ....min. 8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. (b) General nature of industry, (duration) ..... yrs. .... mos. 8 6 business, or establishment in which employed (or employer) CONTRIBUTORY ..... terms, instructions (c) Name of employer (Secondary) ...... (duration) ...... yrs. ..... mos. ..... BIRTHPLACE (city or town) plain 18 Where was disease contracted (State or country) if not at place of death?... Did an operation precede death? Le Date of ..... 10 NAME OF FATHE OF DEATH 11 BIRTHPLACE OF FATHER What test confirmed diagnosis2 (State or country) (Slaned) 12 MAIDEN NAME OF MA ď \*State the DISEASE CAUSING DEATH, or in deaths from VIO-CAUSE LENT CAUSES, state (1) MEANS AND NATURE OF INJURY, 13 BIRTHPLACE OF MOT item (State or country) and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Date of Burial 13 Informant CUPATION (Address) Address onld Registrar

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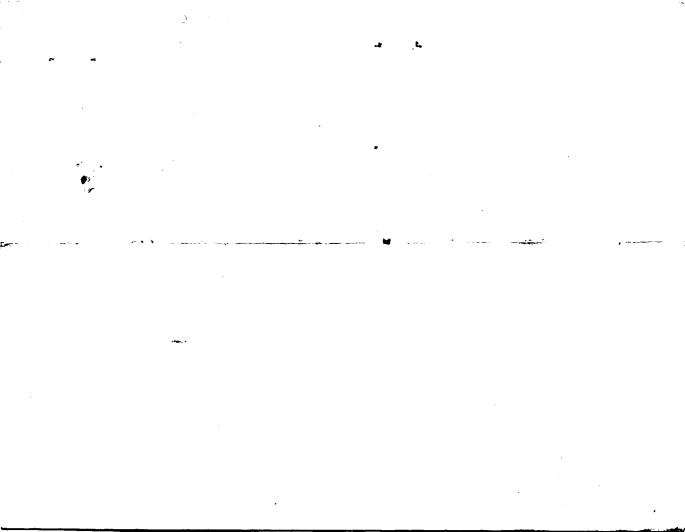
DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

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RECORD be made for STATE OF IDAHO PARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH PERMANENT | RETURN must be the stated. Registration District No. 37 State File No. (If born in hospital or institution Prim. Registration District No...1085 Local Registrar's No. 422. give name.) FULL NAME OF CHILD (If stillboon, substitute the word "Stillbirth" for name of child) Number Date of Legiti-Triplet in order 1934 birth mate? (To be answered only in event of plural births) (Dav) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? SEP Number of child of this mother, including present birth Born alive and now living. Born alive but now dead (Jana) Stillborn. FATHER MOTHER FULL Residence (Usual place of abode). Residence (Usual place of abode). child If nonresident, give place and State If nonresident, give place and State Age at last Birthday 3 Color or rac one (City and State or Country) (City and State or Country) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MINISTEE Born elive PLAINLY I hereby certify that I attended the birth of this child, who was \ Stillborn on the date above stated. (Signature) \*Where there was no attending physician WRITE B—In (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Registrati



| • 00 · 11                                                                       | Ann                                                              | STATE OF IDAH                                              | . 01                                    |                                                                             |
|---------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------|-----------------------------------------------------------------------------|
| AN                                                                              | 1, 001 1 3/1831                                                  | DEPARTMENT OF PUBLIC                                       |                                         | DO NOT WRITE IN THIS SPACE                                                  |
| PHYSICIAN<br>of OCCUPA                                                          | PLACE OF DEATH                                                   | BUREAU OF VITAL ST                                         |                                         | State File No. 79 1 Citi                                                    |
|                                                                                 | County of the Falls                                              | CERTIFICATE OF I                                           | 7                                       | State File No.                                                              |
| E S                                                                             | 1-001                                                            | Registration District No                                   |                                         | Local Registrar's No. 160                                                   |
| = "                                                                             | City of Che Talks                                                | Primary Registration District                              | No. 1085                                | Double Trogramme Trommer Trommer Trommer Tropics                            |
| TTL                                                                             | _                                                                | (No                                                        | name instead of street and              | )                                                                           |
| EXACTLY,<br>act statemer                                                        | of death occu                                                    | rred in a hospital or institution, give it r               | name mistead of sweet and               | Number.                                                                     |
| RECORD<br>EXACT<br>ract state                                                   | 2. FULL NAME                                                     | anax- Unic                                                 |                                         | 10 N mich                                                                   |
| H P.X.                                                                          | (a) Residence. No. / Q.3.                                        | Redapt                                                     | St                                      | If nonresident give city or town and State)                                 |
| etat<br>d.                                                                      | Length of residence in city or town where                        | death occurred. yrs. mos. ds.                              | How long in U.S., if o                  | f foreign birth? yrs. mos. ds.                                              |
| <b>7</b> . 9. 1                                                                 | PERSONAL AND STATIST                                             | ICAL PARTICULARS                                           | MEDICA                                  |                                                                             |
| GRMAI<br>uld be<br>classifi                                                     | 8. SEX 4. COLOR OF RAC                                           | E 5 Single, Married, Widowed, or Divorced (write the word) | 16. DATE OF DEAT                        | 3.                                                                          |
|                                                                                 | te vokele                                                        | and the                                                    |                                         | Month) (Day) (Year)                                                         |
| BINDING IS A PE AGE shou properly c                                             | 5a. If married, widowed, or divorced<br>HUSBAND of               | 7/ ' /                                                     | 17. I HEREBY CERT                       | TFY, That I attended deceased from                                          |
| NIS IS I                                       | (or) WIFE of                                                     | ////                                                       |                                         |                                                                             |
|                                                                                 | 6. DATE OF BIRTH (month, day and yes                             |                                                            | that I last saw h                       | for hour., 19                                                               |
| FOR<br>THIS<br>ed.                                                              | 7. AGE Years Months                                              | Dys If LESS than 1 day,                                    |                                         | i, on the date stated above, atm.                                           |
| ED F<br>K_T<br>pplied<br>may<br>icate.                                          |                                                                  | min.                                                       | The CAUSE OF DEA                        | H* was as follows:                                                          |
| RESERVED I<br>DING INK—1<br>efully supplie<br>so that it may<br>of certificate. | 8. OCCUPATION OF DECEASED                                        | 1/+ 10/2                                                   | sour                                    | municipal .                                                                 |
| SE NG E                                                                         | (a) Trade, profession, or particular kind of work                | William.                                                   |                                         |                                                                             |
|                                                                                 | (b) General nature of industry,<br>business, or establishment in |                                                            |                                         | (duration)yrsmosds.                                                         |
| ES. CE                                                                          | which employed (or employer)                                     |                                                            | CONTRIBUTORY                            |                                                                             |
| MARGIN<br>FH UNFA<br>Ild be can<br>in terms,<br>n on back                       | (c) Name of employer                                             |                                                            | (Secondary)                             |                                                                             |
| MA<br>WITH<br>should<br>plain<br>ction o                                        | 9. BIRTHPLACE (city or town)                                     | daka                                                       | 18. Where was diseas                    | (duration) yrs. mos. ds.                                                    |
| WITI<br>WITI<br>Shoul<br>plair<br>ction                                         | (State or country)                                               |                                                            | if not at place of                      | death?                                                                      |
| NLY,<br>Ition<br>TH in<br>instru                                                | 10. NAME OF FATHER                                               | O) este.                                                   | 1                                       | de death? Date of                                                           |
| ~ ~ ~                                                                           | 10                                                               |                                                            | Was there an autopsy                    | . 0                                                                         |
| PLAI<br>form<br>DEA'<br>See                                                     | 11. BIRTHPLACE OF FATHER (city                                   | or town)                                                   | What test confirmed d                   | Fuel M. D.                                                                  |
| · = .                                                                           |                                                                  | , wasy                                                     | 1/00019                                 | 61) (Address) Turing Ton                                                    |
| WRITE<br>m of j<br>JSE OF                                                       | 12. MAIDEN NAME OF MOTHER                                        | allene show                                                | 77770                                   |                                                                             |
| WRITE<br>item of i<br>AUSE OF                                                   | 13. BIRTHPLACE OF MOTHER (cit                                    | y or town                                                  | *State the DISEASE<br>CAUSES, state (1) | CAUSING DEATH, or in deaths from ENT<br>MEANS AND NATURE OF INJURY, and (2) |
| CAI                                                                             | (State or Country)                                               | - Crown                                                    |                                         | L, SUICIDAL, or HOMCLOAL.                                                   |
| ery<br>ery                                                                      | 14. Informant                                                    | Re 111                                                     | 19. Place of Burial, C                  | remation or Removal Date of Buriat                                          |
| sta<br>is v                                                                     | (Address) / 3 /                                                  | ed apt I talls                                             | Open Today.                             | // De 13 -0                                                                 |
| A B Z                                                                           | 15. Filed Sept 27, 1930                                          | lister & Smith                                             | 20. Undertaker                          | July Pagaress 1                                                             |
| The Tight                                                                       |                                                                  | Registrar                                                  |                                         | park seemides                                                               |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine. etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife. Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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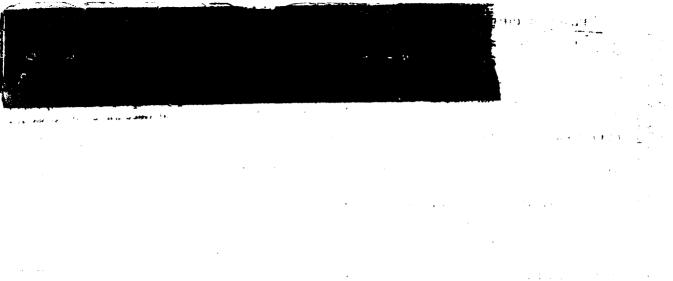
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Do not accept a certificate of death signed only by a

midwife.





| PLACE OF DEATH  PLACE OF DEATH  County of TVin Falls  City of TVin Falls  City of TVin Falls  City of TVin Falls  County Gen.  (If death occurred in a hospital or institution, give its respectively)  Baby Willer | C WELFARE ATISTICS DEATH  State File No                                                                                                                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| (a) Residence. No. Hansen, Id  (Usual place of abode)  Length of residence in city or town where death occurred. yrs. mos. ds.                                                                                      | How long in U. S., if of foreign birth? yrs. mos. ds.                                                                                                         |  |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |  |
| 4. COLOR GR RACE 5. Single, Married, Widowed or Divorsed (write the word)                                                                                                                                           | OC +. 29'Th. 30 (Month) (Day) (Year)                                                                                                                          |  |
| 5a. If married, widowed, or divorced HUSBAND of (or) WIFF of                                                                                                                                                        | HEREBY CERTIFY, That I attended deceased from                                                                                                                 |  |
| 6. DATE OF BIRTH (month, day and year) 7. AGE Years Months Days If LESS than 1 day,                                                                                                                                 | that I last saw h 19 19 19 and that death occurred, on the date stated above, at 813 AM  The CAUSE OF DEATH* was as follows:                                  |  |
| (a) Trade, profession, or particular kind of work  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer                                                 | (duration) yrs. mos. ds.  CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.                                                                                   |  |
| 9. BIRTHPLACE (city or town) (State or country)                                                                                                                                                                     | 18. Where was disease contracted: If not at place of death?                                                                                                   |  |
| 9. BIRTHPLACE (city or town)  10. NAME OF FATHER  HAPOLC M. Miller  Ark.  11. BIRTHPLACE OF FATHER (city or town)  (State or Country)  12. MAIDEN NAME OF MOTHER Effa Allen                                         | Did an operation precede death?  Was there an autopsy?  What test confirmed diagnosis?  (Sieped)  M. D.                                                       |  |
| APK.                                                                                                                                                                                                                | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) WEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMIGIDAL. |  |
| Informant Horald I. Hiller (Address) Hansen, Idaho.                                                                                                                                                                 | 19. Place of Burial, Gremation, or Removal Date of Burial TWin Falls, Ida. Oct.30 19 30                                                                       |  |
| HEODE 15. Filed NOV/5/3.00 Elizabeth Smith                                                                                                                                                                          | 20. Undertaker  1. I. Grossman Twin Falk Lda.                                                                                                                 |  |

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DEPARTMENT OF THE STATE OF TARRED DARRIES BY LIN NO WELL lie miration Marries and and areas and . nadina the look was do will be to be the last The distribute was used to prevent Opicitating Neonal orange Comper of child of the manner, rectuding present birth. as bus also and now make agin alter but new death.... The ball of the colo later of the first and the second of the second o History and Lord of the milders and the L. Hold Survey 2st CERTIFICATE OF ATTENDED PRISERVAN OR WILLIAM Therefore could strate attracted the thris or the dulit, who was studies here care about states. There there was no attending physician Physidian or midwich) or midwife, their the father, bouseholder, intellige & immer stall relater & stilliumin child is one that neither presides nor shows other orbisone of life after birth.

| 70.1                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | · 1/-                                                                                             |
|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| PHYSICIANS                                                                         | NOV 1 1930 STATE OF ID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                   |
| <b>₹</b> 5                                                                         | DEPARTMENT OF PUB                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DO NOT WAITE IN THIS SPACE                                                                        |
|                                                                                    | PLACE OF DEATH BUREAU OF VITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                                           |
| S <sub>Z</sub> ŏ                                                                   | CERTIFICATE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | State File No. 12002                                                                              |
| E P                                                                                | Registration District-No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 86                                                                                                |
|                                                                                    | City of Primary Registration Distri                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | t No. 1010 Local Registrar's No. / 3                                                              |
| H G                                                                                | rimary negistration distri                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | CV 140                                                                                            |
| EECORD<br>EXACTLY,<br>act statemen                                                 | (No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | )                                                                                                 |
| OE<br>AC<br>sta                                                                    | (If death occurred in a hospital or institution give i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ts name instead of street and number.)                                                            |
|                                                                                    | 2. FULL NAME Frankie don n                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | icheli y                                                                                          |
| ENT RECORD stated EXACTLY, Id. Exact statement                                     | (a) Paridones No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Q4                                                                                                |
| 를 <mark>하</mark>                                                                   | (a) Residence. No(Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (If nonresident give city or town and State)                                                      |
| E ST.                                                                              | Length of residence in city or town where death occurred. yrs. mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | is. How long in U. S., if of foreign birth? yrs. mos. ds.                                         |
| ~ ~                                                                                | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF DEATH                                                                      |
| FRMAN<br>uld be<br>classifi                                                        | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 16. DATE OF DEATH                                                                                 |
| ING<br>PERI<br>should                                                              | or Divorced (write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Oat Ind I                                                                                         |
| A B B                                                                              | - Lucian                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (Month) (Day) (Year)                                                                              |
|                                                                                    | 5a. If married, widowed, or divorced HUSBAND of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 17. J. HEREBY CERTIFY, That I attended deceased from                                              |
| BINI<br>IS A<br>AGE<br>prope                                                       | (or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Lho! 90- NA                                                                                       |
| · = =                                                                              | S DATE OF RIPTH (month day and way) Oct - 2 7 1936                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | , 19 <b>2</b> , to 19                                                                             |
| FOR THIS ed.                                                                       | o. Data of Bitti (monal, day and year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | that I last saw harmalive on                                                                      |
| F. L. D. P. O.                                                                     | 7. AGE Years Months Days If LESS than 1 day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | i and that death occurred, on the date stated shove, at                                           |
|                                                                                    | O O O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | The CAUSE OF DEATH* was as follows:                                                               |
| RVED FOUNK—TE supplied. it may tificate.                                           | 8. OCCUPATION OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                   |
| E - + 7                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Still bother                                                                                      |
| RESERVED DING INK efully support to that it read to that it read to that it reads. | (a) Trade, profession, or particular kind of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                   |
| N RESE<br>FADING<br>carefully<br>s, so tha                                         | (b) General nature of industry,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | *                                                                                                 |
| FA Car                                                                             | business, or establishment in which employed (or employer)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ds. ds.                                                                                           |
| 克克 "鲁克"                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CONTRIBUTORY                                                                                      |
|                                                                                    | (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Secondary)                                                                                       |
| MAWITH Should plain ction of                                                       | Ween                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (duration)mosds,                                                                                  |
| M.WITH<br>WITH<br>should<br>plain<br>ction                                         | 9. BIRTHPLACE (city or town) (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 18. Where was disease contracted if not at place of death?                                        |
| · ~ = =                                                                            | 10. NAME OF FATHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                   |
| NLY,<br>ition<br>IH in<br>instru                                                   | Track richels                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Did an operation precede death? Date of                                                           |
| PLAINLY, information DEATH in See instr.                                           | 11. BIRTHPLACE OF FATHER (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Was there an autopsy?                                                                             |
| 4 5 5                                                                              | 11. SIRTHPLACE OF FATHER (city or town)  (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What test confirmed diagnosis?                                                                    |
| 된 참드 <sup>3</sup>                                                                  | Tarno                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (Signed) M. D.                                                                                    |
| B 단 :                                                                              | 12. MAIDEN NAME OF MOTHER AL COLKING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Co. 33 M. (Address) Thum the                                                                      |
| tan of the                                                                         | 4 Gode Everens                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                   |
| SE ES P                                                                            | 18. BIRTHPLACE OF MOTHER (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT                                       |
| WRITE item of i                                                                    | (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| "O PO P                                                                            | The Day of the Control of the Contro |                                                                                                   |
| 396<br>Svery<br>ate (                                                              | 14. Informant Track Nichals                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 19. Place of Burial, Cremation, or Removal Date of Burial                                         |
| Ever<br>state<br>is ver                                                            | (Address) Wesser Ads                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Hellerest Ceculus 10-3- 19 21                                                                     |
| <u> </u>                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20. Undertaker Address                                                                            |
| N. B. should                                                                       | 15. Filed Oct. 13, 1930 W. P. Hamilton                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | P & n + find all                                                                                  |
| z d i                                                                              | Registrar Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | were the were the                                                                                 |

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|                                                                           | RECE: DEC 3 1980 DEPARTMENT OF PUBL                                                        | DAHO                                                                                                   |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| <b>₹</b> 5                                                                | BUREAU OF VITAL S                                                                          |                                                                                                        |
| ₹2                                                                        | PLACE OF DEATH CERTIFICATE OF                                                              | DEATH CX                                                                                               |
| SIC                                                                       | County of 3 annual, Registration District No                                               |                                                                                                        |
| LY, PHYSICIANS statement of 0C-                                           | City of Baucrasto da Primary Registration Distri                                           | ct No. 2/6/ Local Registrar's No.                                                                      |
| te H                                                                      | (No                                                                                        | , give its name instead instead of street and number.)                                                 |
| rta<br>sta                                                                | 2. FULL NAME (St.                                                                          | inator 2                                                                                               |
| et CIE                                                                    |                                                                                            |                                                                                                        |
| RECORD<br>EXACTLY,<br>Exact stat                                          | (a) Residence, No. (Usual place of abode)                                                  | (If nonresident give city or town and State) ds. How long in U. S., if of foreign birth? yrs. mos. ds. |
| A .                                                                       | Length of residence in city or town where death occurred yrs. mos.                         |                                                                                                        |
| NG PERMANENT hould be state erly classified                               | PERSONAL AND STATISTICAL PARTICULARS                                                       | MEDICAL CERTIFICATE OF DEATH                                                                           |
| MANEN<br>I be sta<br>classific                                            | 3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)             | 16 DATE OF DEATH                                                                                       |
| A to                                                                      | Thite single                                                                               | $\frac{19^{3}\delta}{\text{(Month)}}$ (Day) (Year)                                                     |
| ING PERM should perly c                                                   | 5a If married, widowed, or divorced                                                        | (month) (Day) (Teal)                                                                                   |
| E _ * & .                                                                 | HUSBAND of (or) WIFE of                                                                    | 17 HEREBY CERTIFY, That I attended deceased from                                                       |
| FOR BINDIN<br>THIS IS A F<br>ied. AGE sh<br>lay be prope<br>certificate.  | 7 10 1 20                                                                                  | Still first 19 , to , 19 , , , , , , , , , , , , , , , , ,                                             |
|                                                                           | 7 AGE Years : Months : Days   L II LESS than                                               | that I last saw h alive on                                                                             |
| FOJ<br>FIE<br>FIE<br>FIE<br>FIE<br>FIE<br>FIE<br>FIE<br>FIE<br>FIE<br>FIE | hrs.                                                                                       | The CAUSE OF DEATH* was as follows:                                                                    |
| VED FO.  WK.—TH supplied it may                                           | 8 OCCUPATION OF DECEASED                                                                   | Still Firth                                                                                            |
| ERVE<br>FINE<br>Ily su<br>that i                                          | (a) Trade, profession, or particular kind of work                                          |                                                                                                        |
| 12 O A T                                                                  |                                                                                            |                                                                                                        |
| BEFORE S                                                                  | (b) General nature of Industry, business, or establishment in which employed (or employer) | (duration) yrs mos ds.                                                                                 |
| GIN<br>NFA<br>NF Ca<br>be ca<br>rrms,<br>tions                            | (c) Name of employer                                                                       | (Secondary)                                                                                            |
| MARGIN ITH UNFA hould be ca plain terms, instructions                     | Bauer 1/4 Sta                                                                              | (duration) yrs mos ds.                                                                                 |
| MA<br>TH<br>lould<br>lain<br>nstrr                                        | 9 BIRTHPLACE (city or town) Saucraft Sto                                                   | 18 Where was disease contracted If not at place of death?                                              |
| ~ s -                                                                     | 10 NAME OF FATHER 12 +                                                                     | Did an operation precede death? Date of                                                                |
| S H S                                                                     | 170yd. Byughn                                                                              | Was there an autopsy?                                                                                  |
| LAINLY<br>formati<br>DEATH<br>rtant.                                      | 0   11 BIRTHPLACE OF FATHER (city or town) ()                                              | What test confirmed dagnosis?                                                                          |
| E PLAIN<br>of inform<br>OF DEA1<br>important.                             | (State or country)                                                                         | Olar /3 1920 (Address) Burevollar                                                                      |
| E PL<br>of inf<br>OF D                                                    | 12 MAIDEN NAME OF MOTHER HADENER HOLLES                                                    | Mor /3, 1930 (Address) Bureroft and                                                                    |
| E goil                                                                    | 46 DIDTIED ACE OF MOTIFE (sites on town)   //                                              | *State the DISEASE CAUSING DEATH, or in deaths from VIO-                                               |
| WRITE vitem of CAUSE (S very in                                           | (State or country)                                                                         | LENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL. or HOMICIDAL. |
| C Z                                                                       | 14                                                                                         | 19 Place of Burial, Cremation, or Removal   Date of Burial                                             |
| 20                                                                        | (Address)                                                                                  | Place of Burial, Cremation, of Removal                                                                 |
|                                                                           | Visaursell & sa                                                                            | 20. Undertaksir Address                                                                                |
| f. B.–<br>hould<br>UPAT                                                   | 15 Filed Dec -/, 1930 Mrs G. J. Lit                                                        |                                                                                                        |
| <b>.</b>                                                                  | Registrar                                                                                  | " Had - wine                                                                                           |

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STAVES (0) (0) 117/412 (0) DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS -20000a 3 CERTIFICATE OF BIRTH 186040 Registration District No...... ....State File No..... RETURN (If born in hospital or institution Prim\_Registration District No...2/6/Local Registrar's No./0,105 give name.) FULL NAME OF CHILD... birth (If stillborn, substitute the word "Stillbirth" for name of shild) SEPARATE Twin Number Date of Legiti / order of Sex of < Triplet in order Child & hirth mate? (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? 且 FULL FULL MAIDEN NAME Residence (Usual place of abode)... If non-resident, give place and State..... It non-resident, give place and State one Color or race (Years) Birthplace ..... Birthplace ... and (City and State or County) Occupation ..... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. Burgalling I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) ... \*Where there was no attending physician? WRITE or midwife, then the father, householder. (Physician of midwife) etc., should make this return. A stillborn } child is one that neither breathes nor Address shows other evidence of life after birth.

PEACE OF BIRTH

SUPPLIES WELFARE ATHER OF BRIER Registration Manufer No. Pedm. Rossillas (las Plate) de No. if settenen, substitute the work distinction to substitute the August and ander there to answere bush in the start of educat hinters What producted was the provent (reinfields Venetrous) churches weather of this another, including present birth. Signbors .... back won los sells groff Residence Libral place of a line the manufacture after these and faster The source of role! Color or race M. L. Man at lest Hirthday S. Diethalave 3 pouronties | Series and Stele of Mountain Occupation The Common CERTIFICATE OF ATTENDED PHENCIAN OF MOVING SEC. I best who was I attended the birth of this child, who was his birthing out the citie abite states. (Nighature).... Withing there was no uttending physician or utilization then the father, householder. Physic u. David ete should many this return. A ctiliborn child is one that action broather nor shows other withing of the other configure of the after birth.

| ed EXACTLY. PHYSICIAN iy classified. ons on back.                                                                                                                                                                                                                   | PLACE OF DEATH  County of City | DO NOT WRITE IN THIS SPACE  STATISTICS  State File No. 72622  No. 2/6/ Local Registrar's No. 3948                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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| RD.<br>be stated<br>e properly<br>instruction                                                                                                                                                                                                                       | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  N. B.—Every item of information should be carefully supplied. AGE should be should state CAUSE OF DEATH in plain terms, so that it may be present statement of OCCUPATION is very important. See inst | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word.)  5a. If married, widowed, or divorced HUSBAND of (or) WIFE of  6. DATE OF BIRTH (month, day and year)  7. AGE Years Months Days If LESS than 1 day, hrs. or min.  8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work  (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer  9. BIRTHPLACE (city or town) (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (Month)  (Month)  (Month)  (Day)  (Year)  17. I HEREBY CERTIFY, That I attended deceased from  19.33, to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                     | 10. NAME OF FATHER  11. BIRTHPLACE OF FATHER (city or town)  12. MAIDEN NAME OF MOTHER (CITY)  13. BIRTHPLACE OF MOTHER (CITY)  14. Informant (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (Secondary)  (In the secondary)  (In the secon |
| W. I                                                                                                                                                                                                                                                                | 15. Filed 1/27, 19 36 Registrati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 20. Undertaker Addréss Pocallet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

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تأنينا STATE OF IDAHO must be made DEPARTMENT OF PUBLIC WELFARE County of SQ BUREAU OF VITAL STATISTICS City of Poratella CERTIFICATE OF BIRTH Registration District No..... (If born in hospital or institution Prim. Registration District No. 2.14 (Local Registrar's No. 10,090 give name.) P. 00 FULL NAME OF CHILD...... (If stillborn, substitute the word "Stillbirth" for name of shild) Number Twin Date of Logiti-Sex of in order Triplet birth ... mate? 140 Mala Child or other? (To be answered only in event of plural births) (Month) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead......Stillborn .... FATHER FULL MAIDEN MOTHER NAME ..... Residence (Usual place of abode) 1229 M. T. Y. If non-resident, give place and State..... It non-resident, give place and State Birthplace Ma (City and State or County) (City and State or County) Occupation V Vance un 160 CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was I on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Registrar.

BY TERMY OF THE LEGISLE THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAM Beckeration Meriet So. Prim, decientation Digities No. .... Leval Resistant Line. If stillborn, substitute the word, Suillage, Tor store of styles Number in order of high Hal formation a trave of the batterese and a l remain prophylacely with need to prevent ()phthalpide Nooparture: Stillion .... Burn n institut new deal comme ATHER Receipton ( Limit place of shocks I ann mid-ot give place and the made converse to like me I the part of the plant of the part of the p Ten Crack Carrent Birthing (Years) Color or rece. . Line Age at last Allenday Inchesace Converting & County) Hrtholece ... CHY and sing of County . Daeupation . CERTIFICATE OF ATTENDING PHYSICIAN ON MONTH Linguity cartify that I attended the birth of this child, who was saillen on the date above cooled. All here there was he attending physician; Talenta a mainter or unidwife, then the failer, householder. ste, should make this return. A stillborn child is one that astiner breathes nor Address shows other evidence of life after birth.

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The best with the second of the The still out of the second se American 10 to the state of the benefit of the Charles and all bearing the previous Charlestonic Medical rections mean arches of the langue, mellioner mental willing the land and now living anonume. Dame with the same LINTON Andrew United Short of the A . A . Market of the American Manage with the Manage R Marie and other last on onest A POLICE OF MICE AND TO TOTAL and the party mining The proof of Most story story CHARLETTER OF APPEARING PHYSICIAN OR ASSESSED Liverby could that Lampades for bloth of this child, who was talk on the date about stated. (S)Emature) CARRY LIVER WAS BOUTER BEVOLER entireties the father former had a the algorith make this rathers & elithous tro property labeled half san et blos. Direct galls, and la country bean events

| RECORD EXACTLY, PHYSICIANS tact statement of OCCUPA-                                                                                                                                                                                                                                           | 2. FULL NAME Jufant Meader                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | C WELFARE DO NOT WRITE IN THIS SPACE State File No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MARGIN RESERVED FOR BINDING WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT ery item of information should be carefully supplied. AGE should be stated ee CAUSE OF DEATH in plain terms, so that it may be properly classified. Es ery important. See instruction on back of certificate. | (a) Residence. No.  (Usual place of shode) Length of residence in city or town where death occurred. yrs. mer. ds.  PERSONAL AND STATISTICAL PARTICULARS  SEX  4. COLOR BACE  5. Single, Married, Widowed, or Divorced (write the word)  5a. If married, widowed, or divorced HUSBAND of (or) WIFE of  6. DATE OF BIFTH (sonth, day and year)  7. AGE  Months  Days  If LESS than 1 day, hrs. or min.  8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer  9. BIRTHPLACE (city or town) (State or country)  10. NAME OF FATHER  11. BIRTHPLACE OF FATHER (city) town) (State or Country)  12. MAIDEN NAME OF MOTHER  (State or Gountry)  14. Informant  15. BIRTHPLACE OF NOTHER (city) town) (State or Gountry) | MEDICAL CERTIFICATE OF DEATH  16. DATE OF EATH  17. I HEREBY CERTIFY, That I attended deceased from 19. (Month) (Day) (Year)  18. That I last saw h alive on 19. and that death occurred, on the date stated above, at m.  The CAUSE OF, DEATH* was as follows:  (duration) yrs. mos. ds.  CONTRIBUTORY (Secondary)  (duration) yrs. mos. ds.  18. Where was disease contracted if not at place of death?  Did an operation precede death? Date of was there an autopsy?  What test confirmed diagnosis?  (Signed) , M. D.  *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| N. B.—Ev<br>should stat<br>TION is v                                                                                                                                                                                                                                                           | (Address) Prestury Gabb.  15. Filed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2. Udertaker Hendry Address Cary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

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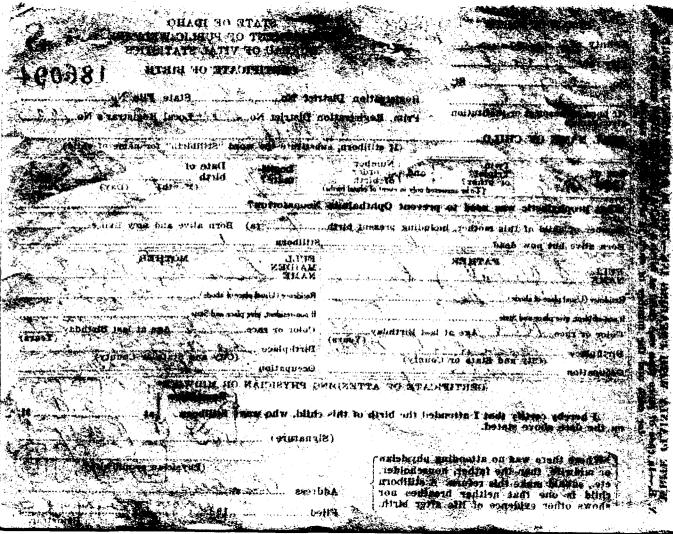
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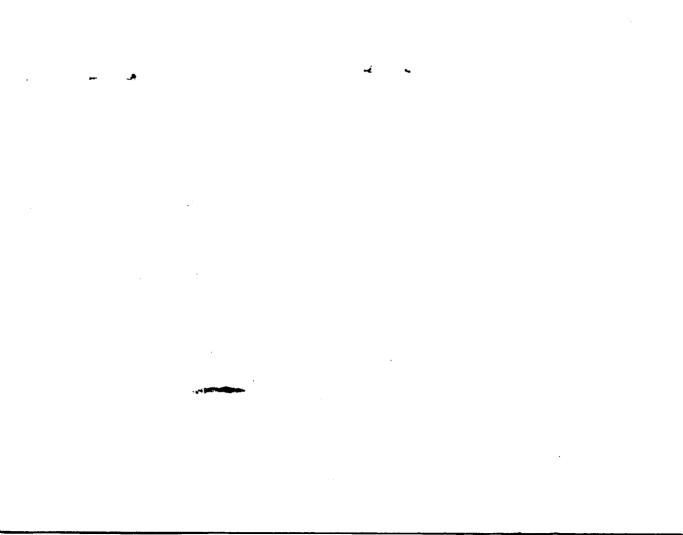
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| Ðå.                                                      | County of BiRFGEIVED DEC 5 1930EPA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | RTMENT OF           | PUBLIC WELFAR                          | E C              |    |
| S S                                                      | City of Blackfoot, Idaho Bu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | JREAU OF VIT        | AL STATISTICS                          | 3                |    |
| SE                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CERTIFICATI         | OF BIRTH                               | 100.44           | _  |
| 22                                                       | No. R.F.D.# I st.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | / =                 | 2                                      | 186142           | Z  |
| 1 to 1                                                   | フィースフィカイ 3/3 Registration Dist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | rict No.            | State File N                           | To               | •  |
| 自                                                        | (If born in hospital or institution                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | - District N. 9     | 1844                                   | istrar's No. 363 | 1  |
| PERMANENT RECORD<br>RETURN must be made for<br>h stated. | give name.) Prim. Registratio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | n District No       |                                        | istrar's No      |    |
| AE SE                                                    | FULL NAME OF CHILD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | el ven              | •                                      |                  |    |
| 쯦단캶                                                      | THE REAL PROPERTY OF THE PROPE | stitute the word "S | tillbirth" for name of                 | child)           |    |
| 교문                                                       | Sex of Twin \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Legiti-             | Date of ovembe                         | r 27 19.30       |    |
| Pire                                                     | Childer ale or other? (To be answered only in event of plural bi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | mate ve S           | birth (Month)                          | (Day) (Year)     |    |
| IS J                                                     | What prophylactic was used to prevent Ophthalmia Neo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | notown ?            |                                        |                  |    |
| K—THIS IS A P<br>a SEPARATE RI<br>in order of birth      | What prophylactic was used to prevent Ophthalmia Neo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | natorum :           | . Thre                                 |                  |    |
| TH                                                       | Number of child of this mother, including present birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (a) Born alive an   | d now living                           |                  |    |
| ြတ္ထ မ                                                   | Born alive but now dead One would.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Stillborn On        | е                                      |                  |    |
| <b>—</b> —                                               | FATHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | FULL                | MOTHER                                 |                  |    |
| j INF<br>birth<br>each,                                  | FULL Hans A. Nansen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | MAIDEN Kati         | e Talme                                | ·                |    |
| ر بر برا<br>رو م                                         | Residence (Usual place of abode Blackfoot, Idaho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Residence (IIsual   | place of abode) Blac                   | kfoct, Idah(     | )  |
| O B                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | l .                 |                                        |                  |    |
| hile<br>ber hil                                          | If nonresident, give place and State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                     | hite                                   | 76               |    |
| N C                                                      | Color or race White Age at last Birthday 40 (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | COIOT OF Pace       | Age at                                 | Last Birthday 36 |    |
| Dogu                                                     | lara 5008 Springs, luano                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Birthplace 500      | a Springs.                             | Id ano ("""      |    |
| TH UNFADING han one child at the number of e             | Occupation Farmer and State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Occupation Hou      | (City and State or Co<br>SC V. 110     | шигу             |    |
| Z = 0                                                    | CERTIFICATE OF ATTENDIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | MIDWIFE*                               |                  |    |
| . 2 4                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                        | 7,30 P. M.       |    |
| PLAINLY<br>ase of mo                                     | I hereby certify that I attended the birth of this chi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ild, who was the    | at.                                    | M.               |    |
| e of N                                                   | on the date above stated. (Sign                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | WYMUM               | 15 N                                   |                  |    |
| PLA                                                      | (bigin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     | ······································ |                  |    |
|                                                          | *Where there was no attending physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | •••••               | (Physician or-mid                      |                  |    |
| ľE<br>In                                                 | or midwife, then the father, householder,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 00                  |                                        | 200              |    |
| WRITE<br>B.—In                                           | etc., should make this return. A stillborn Addre                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ss Igla             | er x fool                              | , vaayay         |    |
| Ma                                                       | shows other evidence of life after birth. Filed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | hace. 2 19          | 30m 10 11                              | elees & later    | نے |
| Ż                                                        | shows owner evidence of the area of this.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <del></del>         |                                        | Registrar.       |    |



| EXACTLY, PHYSICIAN classified. s on back.                                                                                                                                                                                           | DEC 5 1030  DEPARTMENT OF PUBL  BUREAU OF VITAL S  County of City of City of Publ  City of Cit | DO NOT WRITE IN THIS SPACE TATISTICS  DEATH  No. 2/9/2 Local Registrar's No. //3  its name instead of street and number.)                                                                                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| RECORD. hould be stated may be properly See instruction                                                                                                                                                                             | Length of residence in city or town where death occured.  PERSONAL AND STATISTICAL PARTICULARS  3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  17. I HEREBY CERTIFY, That I attended deceased from                                                                                                                                                                                                                    |
| MARGIN RESERVED FOR BINDING INK—THIS IS A PERMANENT RECID be carefully supplied. AGE should be carefully supplied. AGE should be carefully supplied. AGE should be carefully supplied. Supplied to the carefully is very important. | HUSBAND of (or) WIFE of  6. DATE OF BIRTH (month, day and year)  7. AGE Years Months Days If LESS than 1 day, hrs. or Still born min.  8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work  (b) General nature of industry, business, or establishment in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | that I last saw her alive on Nov. 27 1930 19 and that death occurred, on the date stated above, at 8/30 m.  *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, etate (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL SUICIDAL or HOMICIDAL. The CAUSE OF DEATH* was as follows:  Still born |
| MARGI<br>I UNFADING INK—<br>ormation should be c<br>CAUSE OF DEATH<br>statement of OCCUI                                                                                                                                            | which employed (or employer) (c) Name of employer  9. BIRTHPLACE (city or town) Blackfoot, Idaho (State or country)  10. NAME OF FATHER Hans A. Hansen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (duration) yrs. mos. ds.  CONTRIBUTORY Influenza of Mother (Secondary) (duration) yrs. mos. ds.  18. Where was disease contracted                                                                                                                                                                                       |
| Y, WITH n of inforuld state CExact st                                                                                                                                                                                               | 11. BIRTHPLACE OF FATHER (city or town) Soda Springs, (State or Country) Idaho  12. MAIDEN NAME OF MOTHER (city or town) Soda Springs (State or County) Idaho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | if not at place of death?  Did an operation precede death?  NO Date of  Was there an autopsy?  What test confirmed diagnosis?  (Signed)                                                                                                                                                                                 |
| WRITE PLAINL:<br>N. B.—Every iter<br>shoi                                                                                                                                                                                           | 14. Informant dans & Hayson.  15. Filed Mo. 28, 1930 Mmo Halus & all Registrar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NOV 28                                                                                                                                                                                                                                                                                                                  |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery: (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and childran not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidmic cerebrospinal meningitis"); Diptheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia"); Lobar Pneumonia; Bronchopneumonia ("pneumonia," unqualified, is indefite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of ................................ (name origin): "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

**DUTY OF LOCAL REGISTRARS**—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Exercise to plant) I week becelettation District Mo. Prim Predatantina District So. Lond Bresistan Man Thing, autolitate the word Stillett's for some of child Legiti-- Salam Tradie to I abe apprecied and in secon of plant both group de tre ven used en enement Ophthalmus Scounterum? Manney of this worker in tradius present bittle ............. (a) Bein adis and unw tring Look work that the dead HORINA FATRER Posterous Linest giage of alarde states if maniesticat, give place and Steps tor or such as the at last Methoday at MEN TO THE PROPERTY OF THE PARTY OF THE PART Meringue Citiv and draig or conur) se olat aga vitto Decupation BESTEVE OF ATTRIBUTED PHYSICIAN OF MOTOR PO Thursby config that I attended the birth of this child, who was lighted ou the date above status. Where there was no allending physician; Children in the contract of or midwile, then the lather, hauseholder. Late, should ninke this setum. A sillitors! child is uge that notiner breather nor the after evidence of Hie after birth.

|                                                              | 431-106-027-449                                                               | at the                                             |
|--------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------|
| 2                                                            | PLACERTED DEC 2 1930                                                          | STATE OF IDAHO                                     |
| 9 3                                                          |                                                                               | EPARTMENT OF PUBLIC WELFARE                        |
| RECORD ust be ma                                             | 1 1.                                                                          | BUREAU OF VITAL STATIST C                          |
| 5 T                                                          | City of Jeranna                                                               | CERTIFICATE OF BIRTH 186304                        |
|                                                              | No St.                                                                        |                                                    |
| 탈르다                                                          | St Ucileuline Harsail Registration Dist                                       | rict NoState File No                               |
| PERMANENT RECORD<br>TE RETURN must be ma<br>of birth stated. | 486 \$                                                                        | n District NoLocal Registrar's No                  |
| AB #                                                         | C+://01/ )-                                                                   |                                                    |
| A HA                                                         |                                                                               | ibstitute the word "Stillbirth" for name of shild) |
|                                                              | Twin                                                                          |                                                    |
|                                                              | Say of multiple for a lin and an                                              | Legiti- Date of birth birth birth                  |
| 2 H 2                                                        | Child male or other? of birth (To be answered only in event of plural births) | mate? Dirth (Month) (Day) (Year)                   |
| ord PA                                                       | What prophylactic was used to prevent Ophthalmia                              | Neonatorum? 10 % argysl                            |
| SES                                                          | Number of child of this mother, including present birth.                      | 4 (a) Born slive and now living 2                  |
| L 특석                                                         | Born alive but now dead                                                       | •                                                  |
| ¥ E 8                                                        | FATHER //                                                                     |                                                    |
| Ze                                                           | FULL T)                                                                       | MAIDEN MOTHER NAME                                 |
|                                                              |                                                                               |                                                    |
| UNFADING<br>one child a<br>he number                         | Residence (Usual place of abode)                                              | Residence (Usual place of abode Le and sand Walto. |
| A S                                                          | It non-resident, give place and State                                         | If non-resident, give place and State              |
|                                                              | Color or race Lo Littage at last Birthday 75                                  | Color or race. WhileAge at last Birthday. 3 S      |
| _ 3                                                          | Birthplace (Years)                                                            | Birthplace                                         |
| than<br>nd                                                   | my and State or County)                                                       | (City and State or County)                         |
| P t                                                          | Occupation Lange                                                              |                                                    |
| ୍ର ପୂର୍ଣ୍ଣ                                                   | CERTIFICATE OF ATTENDIN                                                       | G PHYSICIAN OR MIDWIFE*                            |
| 2 B 8                                                        | I hereby certify that I attended the birth of this                            |                                                    |
| E of                                                         | on the date above stated.                                                     | cinid, who was stillborn jat                       |
| PL/                                                          | (S                                                                            | ignature) has Holler                               |
|                                                              | (*Where there was no attending physician)                                     | 127, 2                                             |
|                                                              | or midwife, then the father, householder,                                     | (Physician or midwife)                             |
|                                                              | detc., should make this return. A stillborn                                   |                                                    |
| <b>5</b> "                                                   |                                                                               | iress Acrome                                       |
| ×                                                            | shows other evidence of life after birth.                                     | ed ///6 1930 Change Felle                          |
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DEPARTMENT OF PUBLIC WELFARE

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|        |       |    |      |       |

State File No. .....

| BUREAU | OF | VITAL | STA | TISTICS |
|--------|----|-------|-----|---------|

| PLACE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | BUREAU OF VITAL STATISTICS |
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| of Lecome                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CERTIFICATE OF DEATH       |
| OI The Control of the | 16                         |

Local Registrar's No. ..... Primary Registration District No.

(If death occurred in a hospital or institution, give its name instead of street and number.) Balu mecitte

(If nonresident give city or town and State.) How long in U. S. if of foreign birth? yrs.

| (a) Re                                                                                                                                                                                          | sidence. No                                                                        | abode.)        | $\sigma$  | occured. | yrs.      | mos.    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------|-----------|----------|-----------|---------|--|
|                                                                                                                                                                                                 | PERSONAI                                                                           | AND STATI      | STICAL PA | RTICULAI | RS        |         |  |
| 3. SEX                                                                                                                                                                                          | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word.) |                |           |          |           |         |  |
| 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                                                                                                    |                                                                                    |                |           |          |           |         |  |
| 6. DATE OF                                                                                                                                                                                      | BIRTH (mo                                                                          | nth, day and 3 | vear)     |          |           |         |  |
| 7. AGE                                                                                                                                                                                          | Years                                                                              | Months         | Days      |          | LESS than | hrs. or |  |
| 8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer |                                                                                    |                |           |          |           |         |  |
| 9. BIRTHPI<br>(State or                                                                                                                                                                         | ACE (city of country)                                                              | r town         | nom       | Vda      | hs:       |         |  |
| 10. NAM                                                                                                                                                                                         | E OF FATH                                                                          | ER .           | 0 -m      | 00       | f f       |         |  |

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER 13. BIRTHPLACE OF MOTHER (city or town)

Informant

(State or County)

15. Registrar.

MEDICAL CERTIFICATE OF DEATH

(Day)

(Year)

19

16. DATE OF DEATH

(Secondary)

17. I HEREBY CERTIFY, That I attended deceased from 6 1930 to 700 6 , 1930 that I last saw h.\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_\_

and that death occurred, on the date stated above, at..... \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH\* was as follows;

......yrs. .....mos. .... CONTRIBUTORY .....

\_\_\_\_\_ds.\_\_\_\_ds. 18. Where was disease contracted if not at place of death?

Did an operation precede death?..... Date of...... Was there an autopsy?.... What test confirmed diagnosis?....

(Signed) ..... M. D. \_\_\_\_\_, 19..... (Address)......

19. Place of Burial, Cremation, or Removal Date of Burial

Address 20. Undertaker

STATEMENT OF OCCUPATION.—Precise statement of oxupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specifications, as Day laborer Farm laborer, Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife. Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidmic cerebrospinal meningitis"); Diptheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia"): Lobar Pneumonia; Bronchopneumonia ("pneumonia," unqualified, is indefite): Tuberculos's of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of ...... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms: Measles: Whooping Cough: Chronic valvu'ar heart d'sease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia." "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion." "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

PLACE OF BIRTH STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE\_ BUREAU OF VITAL STATISTICS must be CERTIFICATE OF BIRTH 186390 Registration District No. / 00 State File No. (If born in hospital or institution Prim. Registration District No. 2/28. Local Registrar's No. 3/8 give name.) FULL NAME OF CHILD AND (If stillborn, substitute the word "Stillbirth" for name of shild) Number Date of Legiti-Sex of Triplet and 3 birth mate?/ Child 🛴 or other? (To be answered only in event of plural births) (Year) What prophylactic was used to prevent Ophthalmia Neonatorus 2 Born alive but now dead......Q......Stillborn MAIDEN Residence (Usual place of abote) If non-resident, give place and State It non-resident, give place and State. Color or race Whale Age at last Birthday ML Age at last Birthday (City and State or County) (City and State or County) Occupation Music WI Tarme CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was still of the birth of this child, who was on the date above stated. (Signature) \*Where there was no attending physician? or midwife, then the father, householder, etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth.

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DIVISION OF VITAL STATISTICS

## DEPARTMENT OF COMMERCE BUREAU OF VITAL STATISTICS

C.K. MACEY SPECIAL AGENT

Boise, Idaho

DES 29 1930

186390

Mrs. A.E. Niederer Thonront

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT. DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

| FULL NA         | ME OF CHILD                                                                       | uali fa          | ne ) luder    | 62-                     |
|-----------------|-----------------------------------------------------------------------------------|------------------|---------------|-------------------------|
| PLACE O         | F<br>Rexburg                                                                      | DATE OF<br>BIRTH | Nov. 13, 1930 | SEX OF<br>CHILD Female  |
| 2. Numb 3. Born | er of children bor<br>er born alive and<br>alive but now des<br>er of children st | now living       | Sider         | sent birth aght         |
|                 |                                                                                   | (Please wri      | te plainly)   |                         |
| Info            | rmation with refer                                                                | rence to         | Information w | ith reference to        |
| Will            | (Full name)                                                                       | uderes!          | Mary a.       | maiden name)            |
| <del></del>     | (Residence)                                                                       | i.hc_            |               | sidence)                |
| Age at 1        | last birthday #                                                                   | 5                | Age at last b | irthday 57              |
| Soul            | (Birthplace)                                                                      | Wash             |               | en Selati<br>irthplace) |
|                 | (Occupation)                                                                      |                  |               |                         |
|                 |                                                                                   | <del></del>      | <del></del>   |                         |

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C.K. Maccy

Special Agent, Bureau of the Census.

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|                                                              | FC 10 1020 DEPARTMENT OF PUBL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | IC WELFARE DO NOT WRITE IN THIS SPACE                                                                                                                         |
| Z.                                                           | RIDEATI OF VITAL S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | TATISTICS (2.61.)                                                                                                                                             |
| PHYSICIAN                                                    | PLACE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | State File No                                                                                                                                                 |
| ) is                                                         | County of Madeson CERTIFICATE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                               |
| ž                                                            | Registration District No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <del>20                                    </del>                                                                                                             |
| E                                                            | Primary Registration District                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | No. 2/28 Local Registrar's No. 62                                                                                                                             |
|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | - 15 - 15 - 15 - 15 - 15 - 15 - 15 - 15                                                                                                                       |
| ,                                                            | (If death occurred in a hospital or institution, give                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | its name instead of street and number.)                                                                                                                       |
| CTI<br>ified<br>back                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | / 1 <b>D</b>                                                                                                                                                  |
| <5C b0 II                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ·                                                                                                                                                             |
| EX<br>class<br>s on                                          | (a) Residence. No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |
| 5 A B                                                        | (Usual place of abode.)  Length of residence in city or town where death occured. yrs. mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ds. How long in U. S. if of foreign birth? yrs mos. ds.                                                                                                       |
| ate                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |
| st structure                                                 | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF BEATT                                                                                                                                  |
| RECORD sould be may be p                                     | 3. SEX 4. COLOR OR RACE 5. Single. Married, Widow'd, or Divorced (write the word.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 16. DATE OF DEATH                                                                                                                                             |
| 그 잉글로임                                                       | Timals Il fute or Divorced (write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (Month) (Day) (Year)                                                                                                                                          |
| BINDING NENT REC GE should nat it may ortant. See            | 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                               |
|                                                              | 5a. If married, widowed, or divorced HUSBAND of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 17. I HEREBY CERTIFY, That I attended decess d from                                                                                                           |
| Tan Hari                                                     | (or) WIFE of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Buth 19 to 19 19                                                                                                                                              |
|                                                              | 6. DATE OF BIRTH (month, day and year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                               |
| FOR IRMA d. A so t. so t.                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | that I last saw h alive on                                                                                                                                    |
| S CERT                                                       | 7. AGE Years Months Days If LESS than 1 day,hrs. or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | and that death occurred, on the date stated above, at                                                                                                         |
| RVED   S A PE  supplied terms, is very                       | min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| RVI<br>Sup<br>sup<br>ter<br>is                               | 8. OCCUPATION OF DECEASED 1 + 100                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | theth r ACCIDENTAL, SUICIDAL, or HOMICIDAL.  The CAUSE OF DEATH Was as follows:                                                                               |
| 63 W 6                                                       | (a) Trade, profession, or particular kind of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | at It- but I due to                                                                                                                                           |
| RESERVED  TIS IS A P  efully suppli  plain term  TION is ver | particular kind of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 3MM, www.                                                                                                                                                     |
|                                                              | (b) General nature of industry, business, or establishment in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | flacenta-previa                                                                                                                                               |
| MARGIN INK—TI Id be car DEATH ir OCCUPA                      | which employed (or employer)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | /                                                                                                                                                             |
| IARGI<br>INK—<br>I be c<br>EATH<br>OCCUI                     | (c) Name of employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                               |
| FI . TO 1                                                    | 9. BIRTHPLACE (city or town) 12 level 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ds.                                                                                                                                                           |
| ADING<br>on shou<br>E OF 1                                   | (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CONTRIBUTORY                                                                                                                                                  |
| i so ti                                                      | 10. NAME OF FATHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (Secondary)                                                                                                                                                   |
| NFA<br>ation<br>USE<br>teme                                  | Arthur needeer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | dsds.                                                                                                                                                         |
| UNFA<br>rmation<br>CAUSE<br>stateme                          | The state of the s | 18. Where was disease contracted if not at place of death?                                                                                                    |
| E C T                                                        | 11. BIRTHPLACE OF FATHER (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Did an operation precede death? Date of                                                                                                                       |
| e stell                                                      | 11. BIRTHPLACE OF FATHER (city or town) State (State or Country) W 0 8 L L L L L L L L L L L L L L L L L L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Was there an autopsy?                                                                                                                                         |
| B # # X                                                      | 12. MAIDEN NAME OF MOTHER THANK ( Strings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                               |
| Ela K                                                        | man and a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What test confirmed diagnosis                                                                                                                                 |
| Z <del>Z</del> 3                                             | 13. BIRTHPLACE OF MOTHER (city or town) (State or County)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (Signed)                                                                                                                                                      |
| I P                                                          | 2.47                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Address) file (Address)                                                                                                                                      |
| FE PLA                                                       | 14. Water mideir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 19. Place of Burial, Cremation, or Removal Date of Burial                                                                                                     |
|                                                              | Informant (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1 / 1 Sola 1 Mon. 14 19 30                                                                                                                                    |
| E 4                                                          | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 20. Undertaker Address                                                                                                                                        |
| WRITE<br>N. B.—E                                             | 15 Med Dec 4 1930                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Non Attiller willing                                                                                                                                          |
|                                                              | Regiafrar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | " worn frice in the                                                                                                                                           |
|                                                              | [/ [/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | •                                                                                                                                                             |

STATEMENT OF OCCUPATION.—Precise statement of o supation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Saleman. (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager." "Dealer," etc, without more precise specifications, as Day laborer Farm laborer. Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidmic cerebrospinal meningitis"): Diptheria (avoid use of "croup"): Typhoid Fever (never report Typhoid pneumonia"); Lobar Pneumonia: Bronchopneumonia ("pneumonia." unqualified, is indefite): Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma. Sarcoma. etc., of ...... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms: Measles: Whooping Cough; Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.: Brenchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia." "Anaemia" (merely symptomatic) "Atrophy." "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition." "Marasmus." "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide: Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No. 20 State File No. birth stated (If born in hospital or institution . Prim. Registration District No. / Local Registrar's No. / give name.) FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of shild) Number Date of order of Sex of Legitimate?44 Child birth . (To be answered only in event of plural births) (Month) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead......Stillborn FIIIA number Residence (Usual place of abode) It non-resident, give place and State...... If non-resident, give place and State Color or race / V Age at last Birthday (Years) Birthplace ..... Birthplace ..... (Chy and State or County) (City and State or County) Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* case of I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth.

PERMANENT RECORD

PROPERTY OF STREET, ST THE REPORT OF THE PARTY OF THE THE TO STATE OF THE STATE OF TH Resultance Institet No. and the last of th the state of the s CONTRACTOR the stille a substitute the wood estinates a collision the state of the s dist modely battle was used to prevent Ophthabula Reonatorius? mind inseem the court of the co buch won the belle trouble .... Stiffbuet. LUL MALBEY MAATIN SAATIN However Company to the Local prince of the Land prince of the Line the market was the second and the se to br or then I have the the the the total Common of well state of Common ...... soulentrie! The state of the s Decupation CERTIFICATION ATTENDED PRESENTAL OF ATTENDED 1 Stelle Brown Libertin cereirs short I are netted the birth of this child, who was | Stillborn | at ..... the flote share stated. (Signature) Water for was no attenting physician for inidually, then the futher, householder, (Played a second and a second etc. saidthe mater this return. A stillborn this is one will nother breather nor shows affine evidence of life after birth.

| 2.                                                                                            | STATE OF IDAR                                                                                  | HO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| - AP                                                                                          | RECEIVED APR 18 1930 DEPARTMENT OF PUBLIC                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 55                                                                                            | PLACE OF DEATH BUREAU OF VITAL ST                                                              | ATISTICS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| PHYSICIA<br>of OCCUP                                                                          | CERTIFICATE OF                                                                                 | DEATH State File No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                               | County of Registration District No                                                             | 70                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| nt P                                                                                          | City of // Y/////                                                                              | Local Registrar's No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| JY,                                                                                           | Primary Registration District                                                                  | No. March that                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| SEE .                                                                                         | (No. MOMALILLE) (If death occurred in a hospital or institution, give its                      | name instead of street and number.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| RECORD<br>EXACT                                                                               | described in a nospital of institution, give its                                               | and the second of second secon |
| EEX                                                                                           | 2. FULL NAME CO.                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Sta R                                                                                         | (a) Residence. No. 0 606-U Rarl U                                                              | St                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| ate                                                                                           | (Usual place of abode) Length of residence in city or town where death occurred. yrs. mos. ds. | (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs, mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| ING<br>PERMANENT RECORD<br>should be stated EXACTLY, PH<br>rly classified. Exact statement of |                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Eig E                                                                                         | PERSONAL AND STATISTICAL PARTICULARS                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| R P P P P P P P P P P P P P P P P P P P                                                       | 3. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)              | 16. DATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| D E C                                                                                         | mare white                                                                                     | (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                               | 5a. If married, widowed, or divorced                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| BINI<br>S IS A<br>AGE<br>prope                                                                | HUSBAND of<br>(or) WIFE of                                                                     | 17. I HERENY ERTIFY, That I attended deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 70                                                                                            | A DIME OF PROME ( ) I I I                                                                      | 10 10 10 10 10 10 10 10 10 10 10 10 10 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 독표 .월 !                                                                                       | 6. DATE OF BIRTH (month, day and year)  7. AGE Years Months Days If LESS than 1 day,           | 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| te a Ei T                                                                                     | hrs. or                                                                                        | and that death occurred, on the date stated above, atm.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Eg T G E S                                                                                    | min.                                                                                           | The CAUSE OF DEATH. was as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                               | 8. OCCUPATION OF DECEASED                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 6 tat 5 E                                                                                     | (a) Trade, profession, or particular kind of work                                              | Mily & Vlasse ( deat L-8 upg)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| N KES FADIN carefull s, so th                                                                 | (b) General nature of industry.                                                                | 121.000 ALM CAME 9 TO LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Sk are                                                                                        | business, or establishment in which employed (or employer)                                     | (duration)yrsmosds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Para Sign                                                                                     |                                                                                                | CONTRIBUTORY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| B to o to                                                                                     | (c) Name of employer                                                                           | (Secondary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| M<br>ITTH<br>ould<br>lain<br>ion                                                              | 9. BIRTHPLACE (city or town) Wallace,                                                          | (duration)yrs,mosds,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| WITH<br>WITH<br>should<br>plain<br>ction                                                      | (State or country)                                                                             | 18. Where was disease contracted if not at place of death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| . = E_                                                                                        | 10. NAME OF FATHER Q Q                                                                         | Did an operation precede death?Date 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| INL<br>atio                                                                                   | My Manses.                                                                                     | Was there an autopsy?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| PLAINLY information DEATH i                                                                   | 22 11. BIRTHPLACE OF FATHER (city or town)                                                     | What fest confirmed diagnosis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| PLAI<br>nform<br>DEA<br>See                                                                   | 11. BIRTHPLACE OF FATHER (city or town) (State or Country)  A 12. MAIDEN NAME OF MOTHER        | hosigned Miller Nam M. D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 면 '턴 투 추                                                                                      | # Waster Transfer                                                                              | 19 (address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| tan Of                                                                                        | 12. MAIDEN NAME OF MOTHER PROPERTY                                                             | Jo 13 Juness)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| WRITE<br>item of i<br>AUSE OF                                                                 | 13. BIRTHPLACE OF MOTHER (city or town)                                                        | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| WRI<br>item o<br>AUSE<br>import                                                               | (State or Country)                                                                             | CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                               | 14. A 129 massa                                                                                | 19. Place of Burial, Cremation, or Removal   Date of Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Every<br>state (<br>is very                                                                   | Informant (606 Para)                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                               | (Address)                                                                                      | 200) Undertaker 12 Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| MEN N                                                                                         | 15. Filed May 15 1930. F. L. Lingley                                                           | Address Man A to Man A a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| N. B. should                                                                                  | Registray ,                                                                                    | My 10 mills . Hallace                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ,                                                                                             |                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine. etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

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DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

436-223-128851 PLACE OF BIRRECE VED STATE OF IDAHO DEC 1.2 CHEPARTMENT OF PUBLIC WELFARE County of 120 Tenan RECORD BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH 186591 Registration District No.....State File No..... ARATE RETURN (If born in hospital or institution Prim. Registration District No. 105 Local Registrar's No. 197 give name.) FULL NAME OF CHILD birth (If stillborn, substitute the word "Stillbirth" for name of child) Number Date of Legiti-Sex of and Triplet birth Mar. mate? Yu or other? Child Temal (Month) (Day) (Year) (To be answered only in event of plural births) Number of child of this mother, including present birth. (a) Born alive and now living Tra-Born alive but now dead Stillborn MOTHER FULL FATHER MAIDEN FULL Residence (Usual place of abode) 440. If non-resident, give place and State..... It non-resident, give place and State Color or race A. A. Age at last Birthday. Age at last Birthday. 3.3. Color or race ... Birthplace ... (City and State or County) City and State or County) Occupation House wife Occupation ...... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* Horn Allve-I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) .... \*Where there was no attending physician? or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

CARRITATE JATTA TOPU TO THE toristration instrict SERVICE SE LIGERE the to make the statement with with the nationality if tadigue? -titre-THIASE ? Acoust (dinoit) take fault to move at der bremen at 51) hat propertable upon good to meetalt (spiritalistics Noonacorner) Substitution of this mather including present limited to were but now dealer and JUBLICA 114 LV Residence | Line | Steer of a self-Service Control of the Control of th If you resident give pints and that word day the later word Culture or Finence Seminary and miles Chair of their action and the at Brights: A965-111-1151 the unation REPARATE OF AFTENDING PHYSICIAN OR MIDWING Cheering would that I substituted the birth of this child, who was residently fat JAMES STORE MAN WITH HO (Mienature) where there was no agendian physician ; or midwife, then the fasher, betackilder, eic., skould make this return. A stilliota. elilid is one that netther breethen nor white will be sold the status evols

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| 9                                             | PLACE OFFICE VED DEC 1 3 1930 pt                                         | - STATE OF IDAHO                                   |
|-----------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------|
| ا ق                                           | DLU I () (SeU D)                                                         | EPARTMENT OF PUBLIC WELFARE                        |
| T RECORD<br>must be mad                       | County of                                                                | BUREAU OF VITAL STATISTICS                         |
| 용을                                            | City of Salun-                                                           |                                                    |
| <b>A</b> #                                    |                                                                          | CERTIFICATE OF BIRTH                               |
|                                               | No-4 St.                                                                 | A. ~ 186692                                        |
|                                               | him dent partil Registration Dist                                        | rict NoState File No                               |
| S E                                           |                                                                          |                                                    |
|                                               | give name.)                                                              | n District No2. Local Registrar's No               |
| <b>SE 3</b>                                   | FULL NAME OF CHILD. DUCCOTT                                              |                                                    |
| PERMANENT<br>TE REFUEN III<br>I birth stated. | (If stillborn, su                                                        | ibstitute the word "Stillbirth" for name of child) |
|                                               | Twin Number                                                              | Detect Of                                          |
|                                               | Sex of Triplet and in order                                              | Legiti- Date of Oct 27 1939                        |
| 43.5                                          | Child or other? of birth (To be answered only in event of plural births) |                                                    |
| IS A PERMANENT<br>PARATE REFURN I             |                                                                          |                                                    |
| THIS IS SERPAR, in order                      | What prophylactic was used to prevent Ophthalmia                         |                                                    |
| 五次月                                           | Number of child of this mother, including present birth.                 | (a) Born alive and now living home                 |
|                                               | Number of child of this mother, including present sites.                 |                                                    |
| NK<br>birth<br>each                           | Born alive but now dead                                                  | Stillborn                                          |
| o pir                                         | FATHER                                                                   | FULL MOTHER                                        |
| 5 2 2                                         | NAME Vorvan Be Fan                                                       | MAIDEN Margaret Stale                              |
|                                               | NAME I'I' O                                                              |                                                    |
| 222                                           | Residence (Usual place of abode)                                         | Residence (Usual place of abode)                   |
| UNFADING<br>one child a                       | 10                                                                       | If non-resident, give place and Btate              |
| E S                                           | It non-resident, sine place and State                                    |                                                    |
| 200                                           | Color or race Age at last Birthday (Years)                               | Color or race Age at last Birthday (Years)         |
| E 6 5                                         |                                                                          | Birthplace (City and State or County)              |
|                                               | Birthplace (City and State or County)                                    | (City and State or County)                         |
| WITH<br>e than                                | Occupation Auction                                                       | Occupation                                         |
| <b>≱</b> ഉ ∃                                  | CERTIFICATE OF ATTENDIN                                                  | IG PHYSICIAN OR MIDWIFE.                           |
| N 2 2                                         |                                                                          | [Born silve]                                       |
|                                               | I hereby certify that I attended the birth of this                       | child who was Stillhown let 9 V                    |
| ALIN<br>for of                                | on the date above stated.                                                |                                                    |
| PLAINLY for each                              |                                                                          | ignature) J.S. Mryll ins                           |
| 正 费                                           | (6                                                                       | ignature)                                          |
| 8 8                                           | *Where there was no attending physician                                  | ***************************************            |
|                                               | or midwife, then the father, householder,                                | (Physician or midwife)                             |
| WRITE<br>B.—In                                | detc., should make this return. A stillborn                              | * * * * * * * * * * * * * * * * * * *              |
|                                               | Child is one that heritary broken black                                  | dress Naving                                       |
| z                                             | shows other evidence of life after birth.                                | ed/2/10 1980 Cha Bellamy                           |
|                                               | . F11                                                                    | Registrar.                                         |

Princi Reclatration Dietrica No. If stillborn animitiate the word "Stillbirth" for pages of soffen Bate of Leuith rance? (Dest) (AttoM) (admid levely between at view between aid o ] ) What promotects was used to general Ophthalmin Nouneterun? sugator of child of this mother, including present hirtin ..... (3) Borg affen and now living ... modilibern. the now dead FULL MAIDICA Mitigale Country) (City and State, or County) CERTIFICATE OF APPENDING PHYSICIAN OR MIDWIPES TOTAL TRIVE I he arms, correctly that I appended the bleth of this oldfid, who was I Stillborn Dollate officer with out on (Aignaturak .... Typing there was no attending shoulden (Physician or midwife A or mit wife, they the talker, househelder, etc., slicold make this return. A stellborn oblid is one that delther braddles not Address

| io.                                  | PLACE OF BIRTH DEC 1 3 1936                                                                                 | STATE OF IDAHO                                       |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| RECORD<br>be made fo                 | County of The Tall                                                                                          | ARTMENT OF PUBLIC WELFARE UREAU OF VITAL STATISTICS  |
|                                      | City of Turn Falls                                                                                          | CERTIFICATE OF BIRTH                                 |
| 2 2 E                                | No St.                                                                                                      | THE NEW TWO IS A SHARE THE N. 186605                 |
| must                                 |                                                                                                             | rict NoState File No                                 |
|                                      | (If born in hospital of Institution give name.) Prim. Registration                                          | on District No. 2085 Local Registrar's No. 5-0.2     |
| SE SE                                | FULL NAME OF CHILD.                                                                                         | tilliath                                             |
| ETURN stated.                        | (If stillborn, sul                                                                                          | ostitute the word "Stillbirth" for name of child)    |
| A H                                  | Sex of Child and I will and I will and I order or other?  (To be answered only in event of plural by        | Legiti- mate? yes Date of birth (Month) (Day) (Year) |
| PAT of                               | What prophylactic was used to prevent Ophthalmia Neonatorum?                                                |                                                      |
| EFFAR                                | Number of child of this mother, including present birth. 1.6                                                | (a) Born alive and now living                        |
| SE                                   | Born alive but now dead.                                                                                    | Stillborn                                            |
| j INK<br>birth a<br>each, ii         | FULL Frank Weighall                                                                                         | MAIDEN ROTHER WILLS                                  |
| 2 to 2                               | Residence (Usual place of abode)                                                                            | Residence (Usual place of abode)                     |
| child at<br>mber of                  | If nonresident, give place and State 82 9 July                                                              | If nonresident, give place and State R Z John        |
| ONFA<br>one chile<br>one number      | Color or race Age at last Birthday                                                                          | Color or race Age at last Birthday                   |
|                                      | Birthplace Oakley 3 dans (Years)                                                                            | Birthplace (City and State/br Country)               |
| than<br>the                          | Occupation (City and State or Country)                                                                      | Occupation Country)                                  |
| E E                                  | CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*                                                              |                                                      |
| PLAINLY V<br>case of more<br>each an | I hereby certify that I attended the birth of this child, who was Stillborn at M. on the date above stated. |                                                      |
| PLA<br>case (                        | (Sign                                                                                                       | ature)                                               |
|                                      | or midwife, then the father, householder,                                                                   | (Physician or midwife)                               |
| KITE<br>—In                          | etc., should make this return. A stillborn child is one that neither breathes nor Addre                     |                                                      |
| <b>≥</b> ¤                           | shows other evidence of life after birth.                                                                   |                                                      |
| ż                                    | Filed                                                                                                       |                                                      |
| į,                                   | 1                                                                                                           |                                                      |

| <u>•</u>                                                          | PLACE OF BIRTH                                                                                                                                                                                | STATE OF IDAHO 1 Q C R Py -                         |  |
|-------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--|
| <b>₽</b> \$                                                       | County of alles                                                                                                                                                                               | STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARES 667.5. |  |
|                                                                   |                                                                                                                                                                                               |                                                     |  |
|                                                                   | City of Coine                                                                                                                                                                                 | CHARMEN CAMPAGE THE TAN I U 1901                    |  |
| r Re                                                              | No. 16/7 11.24 St                                                                                                                                                                             | CERTIFICATE OF HIRTH                                |  |
|                                                                   | The Sulvation of many Registration Di                                                                                                                                                         | striet NoState File No                              |  |
| ORN                                                               | (If born in hospital or institution   Prim. Registration District No. 1004 Local Registrar's No. 20.    FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of shild) |                                                     |  |
| 253                                                               |                                                                                                                                                                                               |                                                     |  |
| T E                                                               |                                                                                                                                                                                               |                                                     |  |
| a a F                                                             |                                                                                                                                                                                               |                                                     |  |
| HIS IS A PERMANEN'<br>SEPARATE RETURN<br>In order of birth stated | Sex of Twin and Number in order                                                                                                                                                               | 2 Legiti- Date of Dec. 17                           |  |
| A P                                                               | Child Male or other? of birth (To be answered only in event of plural birt                                                                                                                    |                                                     |  |
| A P                                                               | What prophylactic was used to prevent Ophthalmia Neonatoram?  Number of child of this mother, including present birth (a) Born alive and now living 2  Born alive but now dead 0 Stillborn    |                                                     |  |
|                                                                   |                                                                                                                                                                                               |                                                     |  |
| ###                                                               |                                                                                                                                                                                               |                                                     |  |
| 석정                                                                |                                                                                                                                                                                               |                                                     |  |
| Dirth<br>of each                                                  | FATHER C FULL MOTHER                                                                                                                                                                          |                                                     |  |
| マャで∣                                                              | NAME John Joseph Libecomb                                                                                                                                                                     | MAIDEN Javbel Brenner                               |  |
| UNFADINA<br>one child a<br>he number                              | Residence (Usual place of abode) 1115 0 Farrel                                                                                                                                                | Residence (Usual place of abode) // 5 0 7 arel      |  |
| ADIA<br>child<br>umbe                                             | It non-resident, give place and State, Busse, Dula                                                                                                                                            | If non-resident, give place and State Disc State    |  |
|                                                                   | Color or race Colule Age at last Birthday 29                                                                                                                                                  | Color or race (Little Age at last Birthday 22       |  |
| E 6 3                                                             | Birthplace Jennesse (Years                                                                                                                                                                    | Birthplace Keithy Scotland (Years)                  |  |
| # <b>2</b> _                                                      | Birthplace ((City and State or County)                                                                                                                                                        | (City and State or County)                          |  |
| WITH<br>6 than                                                    | Occupation Cook                                                                                                                                                                               | Occupation terripolar                               |  |
| <b>≥ 2</b>                                                        | CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE                                                                                                                                                 |                                                     |  |
| inore<br>more                                                     | I hereby certify that I attended the birth of this child, who was stillbert atat                                                                                                              |                                                     |  |
|                                                                   |                                                                                                                                                                                               |                                                     |  |
| A 2 P                                                             | on the date above stated.                                                                                                                                                                     |                                                     |  |
| PLAINLY case of inc for eac                                       |                                                                                                                                                                                               | Signature)                                          |  |
| - i                                                               | (*Where there was no attending physician)                                                                                                                                                     |                                                     |  |
|                                                                   | or midwife, then the father, householder,                                                                                                                                                     | (Physician or midwife)                              |  |
| <b>2</b>                                                          | etc., should make this return. A stillborn                                                                                                                                                    |                                                     |  |
| <b>≥</b> ¤                                                        |                                                                                                                                                                                               | ddress                                              |  |
| Z                                                                 | shows other evidence of life after birth.                                                                                                                                                     | 11ed/2-29 1930 W. N. Kodle                          |  |
| ļ                                                                 | _                                                                                                                                                                                             | Registrar.                                          |  |

STREET, ON VITAL METTINGER FESTE (10) STACE Marie A STATE OF THE STA and a comment and "desirable of the proper of affection in a security to to Letters (6): **(8)** and section was with to proper Ophishatola Necessian .... of critics in a continue recent their action of the state Stillborn. .... Dant won the could MAILEN PATHER Househouse I want affice of also in ...... I remembrief nive sance and States. 2000 change of change of County Oddrog tion was a feet and MARKET OF ATTEMPTS PRESIDEN OF THE discreted the birth of this child, who was PRiverse there was no attended to reside

Registrar.

STATEMENT OF OCCUPATION .-- Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer." etc. without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidmic cerebrospinal meningitis"); Diptheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia"); Lobar Pneumonia: Bronchopneumonia ("pneumonia." unqualified, is indefite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of ...... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping Cough: Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.: Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sensis, tetanus) may be stated under the head of "Contributory."

**DUTY OF LOCAL REGISTRARS**—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

DEPARTS TO THE PUBLIC WELFARD AU OF THAL STATISTIC CERTIFICATION OF ROUTERS Receiving the District No and the Control of the Received and If born in hospital or instruction of the state of the District of the state of the state of the EFELL NAME OF CHILD to the first of th What prophylacity we need to prevent Different a Nonactorone and a second state of the control of the control of the second se Profitor of place of about when with the Sin and Sin and estimated the history this chile whe will go verify to all a Laure chara a receits on asset sunds excelled to I or midwite, then the mines, moreholder ates, should said this educe. of the contrast of the million of the north of the shorp present income of the after their

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH State File No..... Registration District No. County of Local Registrar's No .... Primary Registration District No. hospital or instrution, givents name/instead instead of street and number.) RECORD (a) Residence. No. (Usual place of abode) (If nonresident give city or town and State) Length of residence in city or town where death occurred ds. How long in U. S., if of foreign birth? mos mos. yra PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH COLOR AR PACE 5 Single, Married, Widowed, 16 DATE OF DEATH or Divorced (write the word) (Month 5a if married, widowed, or divorced **HUSBAND** of HEREBY CERTIFY, That Cattended deceased from 17 (or) WIFE of OF BIRTH (month, day and year) that I last saw har alive on Months Days If LESS than and that death occurred, on the date stated above, at day, \_\_\_\_hrs or .....min. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work... (b) General nature of industry, business, or establishment in \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ which employed (or employer) ..... CONTRIBUTORY ..... (c) Name of employer (Secondary) ...... yrs. ..... mos. .... BIRTHPLACE (city or town) plain 18 Where was disease contracted if not at place of death?...... (State or country) Did an operation precede death?..... Date of ..... Was there an autopsy? What test confirmed flag important. OF. 12 MAIDEN NAME OF MOTHER CAUSE \*State the DISEASE CAUSING DEATH, or in deaths from VIO-13 BIRTHPLACE OF MOTHER/(dyty or town) Very LENT CAUSES, state (1) MEANS AND NATURE OF INJURY. (State or country) and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Cremation, temoval state Informant. ATION (Address) 20. Undertak

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, ▶(b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer." 'Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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Do not accept a certificate of death signed only by a midwife. RECORD be made for STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of... BUREAU OF VITAL STATISTICS City of.... CERTIFICATE OF BIRTH 186830 121 PERMANENT RETURN must Registration District No... State File No. -(If born in hospital or institution Prim. Registration District No. 2194 Local Registrar's No. 399 give name.) FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of child) Number Legiti-Ka Sex of 2 Date of Triplet in order birth ..... Child mate? (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth. Born alive and now living Born alive but now dead... Stillborn.... MOTHER FULL Residence (Usual place of abode) ... Residence (Usual place of abode) .... child If nonresident, give place and State. If nonresident, give place and State... \_\_Age at last Birthday... Age at last Birthday (Years) (Years) Birthplace Birthplace... and State of Country ty and State or Country) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* more Born alive PLAINLY I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) case \*Where there was no attending physician (Physician or <del>midwift</del> or midwife, then the father, householder, WRITE etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth. Registrar.

|                  | VIDAS SATISTICS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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|                  | MOTHER ious place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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A applificen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | or midwife, then                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | -10 care           |
| Registrar        | Sec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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                                                                                                                                                                                                          | THE NAME OF STREET |

| ANS<br>JPA.                                                 | RECE JAN 5                                                                                       | STATE OF IDAI                                               | HO<br>C WELFARE DO 1                                    | OT WRITE IN THIS SPACE                                                                      |
|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------------------------------------|
| YSICI                                                       | PLACE OF DEATH County of Surking                                                                 | CERTIFICATE OF                                              | Alistics                                                | File No                                                                                     |
| Y, PH                                                       | City of Baskelt                                                                                  | Registration District No                                    | No. 2192 I                                              | ocal Registrar's No. 187                                                                    |
| r RECORD<br>ed EXACTLY,<br>Exact statemen                   | 2. FULL NAME                                                                                     | red in a hospital or institution, give ita                  | name instead of street and number                       | 206                                                                                         |
| F =                                                         | (a) Residence. No(Usual place of abode) Length of residence in city or town where                | leath occurred. gravinos da                                 | St. (If nonre                                           | sident give city or town and State)<br>n birth? yrs. mos. ds.                               |
| ANJ<br>be sified                                            | PERSONAL AND STATIST                                                                             |                                                             | MEDICAL CER                                             | TIFICATE OF DEATH                                                                           |
| PERMANER Should be starty classified.                       | 8. SEX 4. COLOR OR RAC White                                                                     | E 5. Single, Married, Widowed, or Divorced (write the word) | 16. DATE OF DEATH                                       | 12 1930<br>(Day) (Year)                                                                     |
| S IS A P. AGE sho properly                                  | 5a, If married, widowed, or divorced<br>HUSBAND of<br>(or) WIFE of                               | 0                                                           | 17. I HEREBY CERTIFY, Th                                | (                                                                                           |
| HIS H                                                       | 6. DATE OF BIRTH (month, day and year                                                            | •)                                                          | that I last saw h Lingalive or                          | 0                                                                                           |
|                                                             | 7. AGE Years Months O                                                                            | Days If LESS than 1 day, hrs. or                            | Į.                                                      | date stated above, at 10:45 am.                                                             |
|                                                             | 8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work.                    | Noul_                                                       | The CAUSE OF DEATH* was                                 | as follows:                                                                                 |
| IN RESE<br>FADING<br>carefully<br>is, so that<br>ack of cer | (b) General nature of industry,<br>business, or establishment in<br>which employed (or employer) | noul                                                        |                                                         | duration)yrs mos ds.                                                                        |
| De pe term on pr                                            | (c) Name of employer                                                                             | naul                                                        | (Secondary)                                             |                                                                                             |
| WITH<br>Should<br>plain<br>ction                            | 9. BIRTHPLACE (city or town) 6                                                                   | asult. She                                                  | 18. Where was disease contractif not at place of death? | duration) yrs. mos. ds.                                                                     |
| , a 2                                                       | 10. SAME OF FATHER                                                                               | · lines                                                     | Did an operation precede death                          | 7 No Date of                                                                                |
| PLAINLY information DEATH in See institution                | 211. BIRTHPLACE OF FATHER (city (State or Country)                                               | or town) Utah                                               | Was there an autopsy? What test confirmed diagnosis?    | Music Physics oligns                                                                        |
| a Office                                                    | 12, MAIDEN NAME OF MOTHER                                                                        | ide Mindall                                                 |                                                         | Address Chilley, Sla                                                                        |
|                                                             | 18. BIRTHPLACE OF MOTHER (city (State or Country)                                                | or town)                                                    | CAUSES, state (1) MEANS whether ACCIDENTAL, SUIC        | NG DEATH, or in deaths from VIOLENT<br>AND NATURE OF INJURY, and (2)<br>IDAL, or HOMICIDAL. |
| Ever;<br>tate                                               | 14. Informant Colas arm (Address) Possible Color                                                 | strongi                                                     | 19. Place of Burial, Cremation                          | or Removal Date of Burial                                                                   |
| N. B.—.<br>should a<br>TION is                              | 16. Filed 12. 23, 1930 MK                                                                        | Muis Elatra.                                                | 20. Undertaker                                          | Address Connect to the                                                                      |
| <b>4 a E</b>                                                |                                                                                                  |                                                             |                                                         |                                                                                             |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer. Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery: (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine. etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife. Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs. meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of ...... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia." "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
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DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

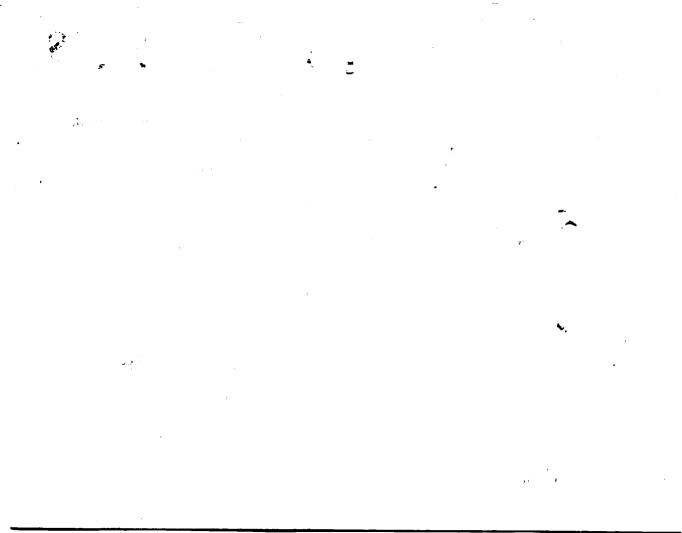
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Do not accept a certificate of death signed only by a

midwife.

must be made PLACE OF STATE OF IDAHO HIS IS A PERMANENT RECORD SEPARATE RETURN must be ma DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH State File No.... Registration District No... (If born in hospital or institution Prim. Registration District No.2/.V. Local Registrar's No.3 give name.) birth FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number ö Sex of Date of Legitiand in order Child O mate? Use birth 11 (To be answered only in event of plural highe) (Month) What prophylactic was used to prevent Ophthalmia Neonatorum? Number child of this mother, including present birth. (a) Born alive and now living. Born alive but now dead Stillborn 3. FATHER FULL MOTHER MAIDENO NAME ... Residence (Usual place of abode) It non-resident, give place and State If non-resident, give place and State..... Color or race... Age at last Birthday... Color or race. W. Age at last Birthday... Birthplace (9 (City and State or County) (City and State or County) Occupation Santa CERTIFICATE OF ATTENDING PHYSICIAN OR MINWIFE. PLAINLY case of mo I hereby certify that I attended the birth of this child, who was on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder. (Physiciantor mid-fr etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Registrat



MARGIN RESERVED FOR BINDING

| 11         | STATE OF IDAH                                                                       | (O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|            | RECEIVED JAN 2 1931 DEPARTMENT OF PUBLIC                                            | WELFARE DO NOT WRITE IN THIS SPACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| li         | BUREAU OF VITAL ST                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|            | ~ SLACE OF DEATH                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 11         | County of Va Caracter 11 to 11 to 12                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|            | City of Table 73115 Registration District 10.                                       | No. 2/1/0 Local Registrar's No. 23/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|            | <i></i>                                                                             | A CONTRACTOR OF THE PARTY OF TH |
| .          | (If death occurred in a hospital or institution, give it                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ∥.         |                                                                                     | The state of the s |
|            | <b>~</b>                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| í    _     | (Usual place of abode.)                                                             | St. (If nonresident give city or town and State.)  ds. How long in U. S. if of foreign birth? yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| i II       | ength of residence in city or town where death occured. yrs. mos.                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 3          | PERSONAL AND STATISTICAL PARTICULARS                                                | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 3          | . SEX  4. COLOR OR RACE  5. Single, Married, Widowed, or Divorced (write the word.) | 16. DATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|            | male white single                                                                   | (Month) (Day) (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| ll ll      | a. If married, widowed, or divorced                                                 | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|            | HUSBAND of (or) WIFE of                                                             | 17. I HEREBI CERTIT I, 19, 19, 19, 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|            | - 1000                                                                              | that I last saw h alive on 19 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|            | B. DATE OF BIRTH (month, day and year)                                              | and that death occurred, on the date stated above, at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|            | 7. AGE Years Months Days If LESS than I day, hrs. or                                | and that death occurred, on the date of the deaths from VIOLENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| very       |                                                                                     | *State-the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH* was as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|            | 3. OCCUPATION OF DECEASED  (a) Trade, profession, or                                | The CAUSE OF DEATH* was as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| OCCUPATION | particular kind of work                                                             | Itils-Torn-Mon-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| A I        | (b) General nature of industry, business, or establishment in                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 3          | which employed (or employer)                                                        | strong- and &                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| ટું ∥_     | (c) Name of employer                                                                | (duration) yrs. mos. ds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 5          | 9. BIRTHPLACE (city or town) Idaho Falls, Benneville Co                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| °   _      | 1 2-43 %                                                                            | CONTRIBUTORY (Secondary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| statement  | 10. NAME OF FATHER                                                                  | (duration)yrsmosds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| a          | Coppar III. Person Con                                                              | 18. Where was disease contracted if not at place of death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| ct sta     | 11. BIRTHPLACE OF FATHER (city or town)                                             | Did an operation precede death?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Xac<br>ARE |                                                                                     | Was there an autorsy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| E A        | 12. MAIDEN NAME OF MOTHER Ruth Munsee                                               | What test confirmed diagnosis?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|            | 13. BIRTHPLACE OF MOTHER (city or town)                                             | (Signed)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| _          | (State or County)                                                                   | Della 19 30 (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| i i        | 11. ( Miller M.) Ded Jack                                                           | 19. Place of Burial, Cremation, or Removal Date of Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|            | Informant (Address)                                                                 | Sphales talloted 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| -          | 16.                                                                                 | 20. Undertaker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| l          | Filed Registrar.                                                                    | none !                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

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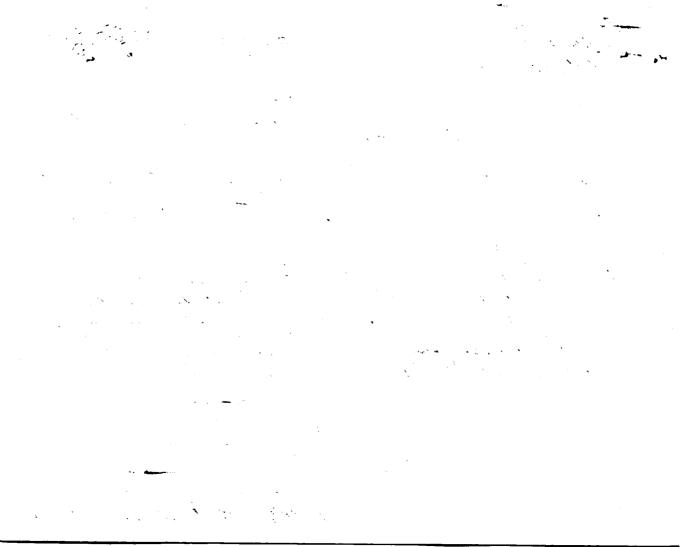
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RECEIVED JAN 3 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE PLACE OF DEATH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH State File No... County of Registration District No. Local Registrar's No. 3/ Primary Registration District No. 2159 (No. (If death occurred hespital or institution, give its name instead of street and number.) 2. FULL NAME (a) Residence. No. (If nonresident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. di (Usual place of abode) Length of residence in city or town where death occurred. AGE should be st properly classified. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS Single, Married, Widowed, 16. DATE OF DEATH (Month) 5a. If married, widowed, or divorced HUSBAND of 17. I HEREBY CERTIFY, That I attended deceased from (or) WIFE of 19 30 to al time hovizz 6. DATE OF BIRTH (month, day and year) that I last saw h\_\_\_ - Days supplied. 7. AGE Years Months If LESS than 1 day. hat it may certificate. and that death occurred, on the date stated above, at..... The CAUSE QF DEATH\* was as follows: \_\_\_\_min. 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in .....(duration) \_\_\_\_\_yrs. \_\_\_\_mos. which employed (or employer) term CONTRIBUTORY (c) Name of employer (Secondary) plain ction o (duration) yrs. mos. 9. BIRTHPLACE (city or town 18. Where was disease contracted (State or country) if not at place of death? .. ij. Did an operation precede death? Date of DEATH See inst Was there an autopsy? ... PARENTS 11. BIRTHPLACE OF FATHER (city or tow What test confirmed disk nosis? (State or Country) OF. important. AUSE \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 13. BIRTHPLACE OF MOTHER (State or Country) Date of Burial state is ver Informan (Address)

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STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia." "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

| VT RECORD<br>f must be made<br>d.     | No. St.                                                                                                                         | STATE OF IDAHO EPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRT 187162 trict No |
|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| RMANENT<br>RETURN m                   | give name.)                                                                                                                     | n District No Local Registrar's No.                                                                       |
| REST                                  | FULL NAME OF CHILD MUNICIPALITY                                                                                                 | ubstitute the word "Stillbirth" for name of shild)                                                        |
| ATE                                   | Sex of Twin   Number Triplet   and   in order or other?   of birth (To be answered only in event of plural births)              | Legiti- Date of hirth Nov 3                                                                               |
| HIS IS SEPAR                          | What prophylactic was used to prevent Ophthalmia                                                                                | Neonatorum? Lilver nettate 296                                                                            |
|                                       | Number of child of this mother, including present birth.                                                                        |                                                                                                           |
| NK<br>birth<br>each                   | Born alive but now dead.                                                                                                        |                                                                                                           |
| of Bridge                             | FULL Joseph Le Ray James                                                                                                        | MAIDEN VINGINIA CALLON                                                                                    |
| FADING<br>child<br>number             | Residence (Chast place of abode) Muntale                                                                                        | Residence (Usual place of bode) mustaugh                                                                  |
| FA<br>o cl                            | It non-resident, give place and State                                                                                           | If non-resident, give place and State.                                                                    |
| UNF<br>the m                          | Color or race What Age at last Birthday (Years)                                                                                 | Color or race                                                                                             |
| WITH<br>e than                        | Occupation City and State or County)                                                                                            | City and State or County Occupation                                                                       |
| PLAINLY W<br>case of more<br>for each | CERTIFICATE OF ATTENDIN  I hereby certify that I attended the birth of this on the date above stated.                           | G PHYSICIAN OR MIDWIFE.  [ Born alive ]                                                                   |
| PLA                                   |                                                                                                                                 | gnature) Huel E. Dan                                                                                      |
| E F                                   | *Where there was no attending physician                                                                                         | o M B                                                                                                     |
| WRITE<br>B.—In                        | or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor Add | (Physician or midwife)                                                                                    |
| ×                                     | shows other evidence of life after birth.                                                                                       | ***************************************                                                                   |
|                                       |                                                                                                                                 | Registrar.                                                                                                |

ATE TO TO AH DEPARTMENT OF PUBLIC WILLPARE BUREAU OF VITAL STATISTICS CHRISTINIATE OF BILL Registration Discrict No. molticitient to intimend at a Erim Registration District No. ... Local Bertarans S. the floor, substitute (b. word "stilling to age of this ditte. in other? Bulle" it. To be answered only in a state but being being dinasth. That invalidatile was used to prevent (ighthulation Venuatorum?) Numbered abild of this mother, including present birther and for any their after and one to the con-Born alive but now dond 319414141017 MEATHER 二 、 直接主义 the state of the s medicines with room theritary can if Color of the last to and the Same of the man the color resistant PRET 11 11 Sand Stain F. County dark and store or Country with Occupation . . . Description CERTIFICATE OF TOTAL OR THE PRESCULN OR STERRIES Home Allve . Lhenchy certify that I attended the birth of this child, who mad Scheim . to the the aluste winter. · isignatura. which there was no attending physician or midwife, their the futher, householder, (Physician of inhimital election water this return. A stillingen title is one that soither breather nor Address shailes other evidence of life after but o.

MARGIN RESERVED FOR BINDING

| FFC DEC 23 1930                                                                                                  |                                                          | IC WELFARE DO NO                                                                                                | T WRITE IN TH                                              | S 1 9 4                              |
|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------|
| V PLACE OF DEATH Cassia County of                                                                                | BUREAU OF VITAL S CERTIFICATE OF                         | DEATH                                                                                                           | le No.                                                     | 0.1.3.5                              |
| City of Prim                                                                                                     | ary Registration District                                |                                                                                                                 |                                                            | trar's No                            |
| 2. FULL NAME Baby Squires                                                                                        |                                                          |                                                                                                                 |                                                            |                                      |
| (a) Residence. No.  (Usual place of abode.)  Length of residence in city or town where death                     |                                                          | ds. How long in U. S. if                                                                                        | nonresident give city<br>of foreign birth?                 | or town and State.)<br>yrs. mos. ds. |
| PERSONAL AND STATISTICAL PA                                                                                      | RTICULARS                                                | MEDICAL                                                                                                         | CERTIFICATE OF I                                           | DEATH                                |
| 3. SEX 4. COLOR OR RACE 5. or                                                                                    | Single, Married, Widowed,<br>Divorces 1 with 1the word.) | 16. DATE OF DEATH NOV. 3 1                                                                                      |                                                            | , 19<br>(Year)                       |
| 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                     |                                                          | 17. I HEREBY CERTIFY,                                                                                           | That I attended dec                                        |                                      |
| 6. DATE OF BIRTH (month, day and year)                                                                           | ov. 3 1930                                               | that I last saw hanner al                                                                                       | \                                                          | フ 19 <sup>フ</sup> 4                  |
| 7. AGE Years Months Days STILL BORN                                                                              | If LESS than 1 day,<br>hrs, or<br>min.                   | and that death occurred  *State the PISEASE CA CAUSES, state (1) MEA whether ACCIDENTAL, SI THE CAUSE OF DEATH* | , on the date stated<br>USING DEATH, or i<br>NS AND NATURE | above, at                            |
| 8. OCCUPATION OF DECEASED  (a) Trade, profession, or particular kind of work                                     |                                                          | w hether ACCIDENTAL, SI<br>The CAUSE OF DEATH*                                                                  | was as follows:                                            | Coglinaci                            |
| (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer | •                                                        |                                                                                                                 |                                                            |                                      |
| 9. BIRTHPLACE (city or town)                                                                                     |                                                          |                                                                                                                 | (duration)                                                 | yrs,nos,                             |
| 10. NAME OF FATHER ROY Squi                                                                                      | Idaho.                                                   | (Secondary)                                                                                                     |                                                            | yrs,mos                              |
| 211. BIRTHPLACE OF FATHER (city or town (State or Country)                                                       |                                                          | 18. Where was disease confirmed at place of determined by the Did an operation precede                          | atn !                                                      | te of                                |
| 12. MAIDEN NAME OF MOTHER Virg                                                                                   | inia Anderson                                            | Was there an autopsy? What test confirmed dia                                                                   | بعباق ح                                                    | nie                                  |
| 13. BIRTHPLACE OF MOTHER (city or town (State or County)                                                         | no.                                                      | (Signed) 51                                                                                                     | (Audress)                                                  | men                                  |
| 14. Mrs. Virginia Squ<br>(Address) Murtaugh Ida                                                                  | ires                                                     | 19. Place of Burial, Crem<br>Burley Ida                                                                         | nation, or Removal                                         | Nov. 5-3Q                            |
| 15. Filed 19.30                                                                                                  | HCulter<br>Registrar.                                    | 20. Undertaker D.E.Johnson                                                                                      | Burl                                                       | Address<br>9y Ida.                   |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Saleman. (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager." "Dealer." etc. without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidmic cerebrospinal meningitis"); Diptheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia"); Lobar Pneumonia: Bronchopneumonia ("pneumonia," unqualified, is indefite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma. Sarcoma, etc., of ...... (name origin): "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms: Measles: Whooping Cough; Chronic valvular heart disease: Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia." "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

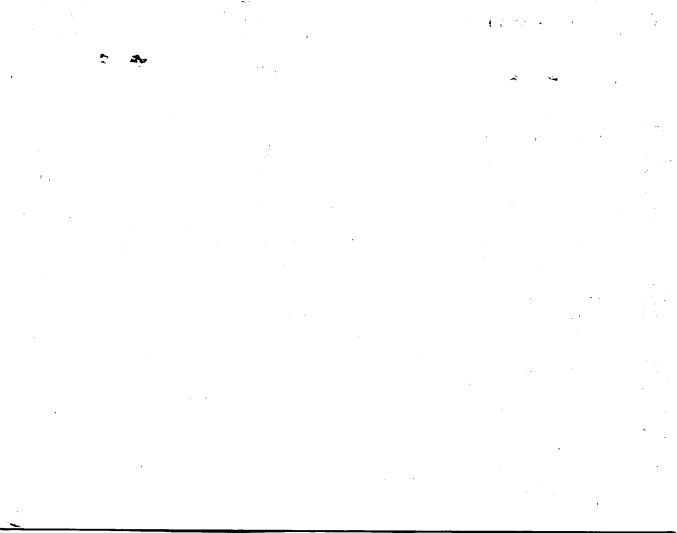
Do not accept a certificate of death signed only by a midwife.

| PERMANENT RECORD<br>E RETURN must be made<br>birth stated. | County of 16 St. STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTE 187163                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| S N                                                        | Registration District No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| ANEN<br>FURN<br>stated                                     | (If born in hospital or institution give name.)  Prim. Registration District NoLocal Registrar's No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| MA PER                                                     | FULL NAME OF CHILD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| PERM<br>TE RES                                             | (If stillborn, substitute the word "Stillbirth" for name of shild)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| ATO                                                        | Sex of Child Gay Twin and Number in order of birth Cor other? (To be answered only in event of plural births)    Number in order of birth cor of bir |
| S IS<br>SPAR<br>order                                      | What prophylactic was used to prevent Ophthalmia Neonatorum?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| H 22 H                                                     | Number of child of this mother, including present birth. (a) Born alive and now living                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| K_1<br>frth a<br>each,                                     | Born alive but now deadStillborn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| at b                                                       | FULL Joseph La                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| FADINC<br>e child<br>number                                | Residence (Usual place of abode) . Residence (Usual place of abode) . Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| S. C.                                                      | It non-resident, give place and State.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                            | Color or race. Age at last Birthday. Color or race. W. Age at last Birthday.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 73                                                         | Birthplace Birthplace (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| WITH<br>e than                                             | Occupation (City and State or County) Occupation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                            | CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| PLAINLY<br>case of mo                                      | I hereby certify that I attended the birth of this child, who was Stillborn at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| PIL.                                                       | (Signature) Luch & Dean                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                            | (*Where there was no attending physician)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| WRITE<br>B.—In                                             | or midwife, then the father, householder,  (Physician or midwife)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| ¥a.                                                        | etc., should make this return. A stillborn child is one that neither breathes nor Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| ×                                                          | shows other evidence of life after birth. Filed /- 2 - 193/ Flexity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| ļi                                                         | Registrar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

STATE OF IBERO DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISME CHREPTCYCE OF RIGHT Registration District No. ..... State Ette No. in hospital or methadion Prim. Registration District No. Local Registrar's No. It at born, substitute the word Stittes in tor name of said Date of -intend mate? 111.00 section thanks to person in the terror was not a ! What usonished on us used to prevent Opithalanda Sconatorum? Number of child of this mulher, including present been, an electronic Born alive and now being wife HOLD SHYS DUL HOSE COME. \* SHIROM del J'i reliable to make letter it reaching t nd the final works on its traditional recogniti (Clerifical state or Councy) Calledon of Charles CHETHER ATE OF ATTRAINS PHYSICIAN OR MIDWINE. -9716 WICE I hereby certify that I attended the birth of this chief, who was stillborn on the date above stated (Surneture) . To charles Borro there was no attending physician or widelle, then the fither, householder, (Physician or miduale) etc., should make this return. A etiliborn didd is one that beither breathes unr. shows other evidence of life after birth.

STATE OF IDAHO 1031 DEPARTMENT OF PUBLIC WELFARE County of BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTHT (If born in hospital or institution Prim. Registration District No 20.1. Local Registrar's No...... give name.) FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number in order Date of Legiti-Sex of Triplet and mate?//co birth . Child 4 or other? (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? FULL MOTHER EATHER MAIDEN TITITA NAME . number Residence (Usual place of abode)... Residence (Usual place of abode) If non-resident, give place and State It non-resident, give place and State. Age at last Birthday O Color or pace .......Age at last Birthday. Birthplace Birthplace (Olty and State or County) State or County) Occupation ..... oughour CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Registrar.

RECORD



| PERMANENT RECORD be stated EXACTLY, PHYSICIANS should ed. Exact statement of OCCUPATION is   | TORM V. S. NEWERING. JAN 1984  1. PLACE OF DEATH  County of Registration District No.  Primary Registration District No.  (No.  (No.  Primary Registration District No.  (No.  Example 1984  Primary Registration District No.  (No.  Primary Registration District No.  (No.  Example 1984  P | BUREAU OF VITAL STATISTICS  State File No. 73.2 (1)  Local Registrar's No.  If death occurred in a hospital, institution or camp, give its NAME instead of street and number.                            |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| figheraneny recolusive stated exactive, be stated exactive, ed. Exact statement              | PERSONAL AND STATISTICAL PARTICULARS  8. SEX 4. COLOR OR BACE 5. SINGLE, MARRIED, WID- OWED OR DIVORCED  (Write the word)  6. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 16. DATE OF DEATH  (Month) (Day) (Year)                                                                                                                                                                  |
| FOR BINDIN<br>THIS IS A 1<br>AGE should<br>operly classifi                                   | 7. AGE (Month) (Day) (Year)  7. AGE   IF LESS than 1   day how many                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | that I last saw h alive on 19 , and that death occurred on the date stated above, at M.  The CAUSE OF DEATH* was as follows:                                                                             |
| BGIN RESERVED<br>UNFADING INK—<br>carefully supplied,<br>that it may be pre-<br>certificate. | (a) Trade, profession or particular kind of work (b) General nature of industry, business or establishment in which employed (or employer)  9. BIRTHPLACE (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Spirit Biffile  (Duration) yrs. mos. ds.  Contributory (Secondary)  (Duration) yrs. mos. ds.                                                                                                             |
| MA<br>PLAINLY, WITH<br>rnation should be<br>in plain terms, so<br>uctions on back of         | 10. NAME OF Father  11. BIRTHPLACE OF FATHER (State or Country Culturis Canada  12. MAIDEN NAME) OF MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | *State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.  18. LENGTH OF RESIDENCE (For Hospitals, Institutions, |
| WRITE PL<br>—Every item of inform<br>CAUSE OF DEATH in<br>important. See instruc             | 18. BIRTHPLACE OF MOTHER (State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | At place In the of deathyrsmosdays. Stateyrsmosds.  Where was disease contracted if not at place of death?                                                                                               |
| N. B. state (very in                                                                         | Filed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 20. UNDERTAKER ADDRESS                                                                                                                                                                                   |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman. (b) Grocery; (a) Foreman. (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager." "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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PLACE OF BIRTH LD DEC 2 8 1980 STATE OF IDARO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH Registration District No......State File No..... (If born in hospital or institution Prim. Registration District No.....Local Registrar's No..... give name.) FULL NAME OF CHILD (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number Sex of Date of Legiti-Triplet in order Child 214 mate? 40 birth or other? (To be answered only in event of plural births) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth. Manual (a) Born alive and now living. FULL MAIDEN Residence (Usual place of abode). Residence (Usual place of abide) 1544 It non-resident, give place sad State. If non-resident, give place and State\_a.... ...Age at last Birthday 32 A.Age at last Birthday... Birthplace ..... (City and State or County) (City and State or County) Occupation ..... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFF. Born slive I hereby certify that I attended the birth of this child, who was | Stillborn on the date above stated. (Signature) ... \*Where there was no attending physician or midwife, then the father, householder. (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Filed/2 -12-19 Registrar.

DEPLETE OF PUBLIC WELL RE THE ALL OF LANGE STATISTICS HITCHIN TO MEATERS AND registration District No. State File 30. If born in boseined to just liver in Print, Registration Withers No. Local Registran's No. sive mame.). FULL XAME OF CHILD ill seilleden, entreffigle the word "Sillhitth" fur name of the lanmarket fire them (Month) विभिन्न के The bearing only in exercise states bride What prophylactic was used to prevent (mathabala Neunatorum? Auniler of child, of this mother, inche buy present birth. Little and Born abro and now living \_\_ grodlii38..... More alive out now dead ...... AND THE PARTY OF T Mind there ( Court ) seems the contract of the th non-regions and being and being Colui or care Colui or care or last elithan collare or rate believed Are at last Birthday . ... enalgd#### : THE THE STATE OF THE COURTY (Clif and there per Constitut ... etecapation .... CERTIFICATE OF ATTRODING PHYSICIAN OR MIDWHEN Acres after Thereby certify that I attended the birth of this child, who was I malbern . In from the date above stated. (Singulation) "Where there was no attending physician; or infligite, then the father, householder, (Phraiclan or had wife) the should make this return. A stillborn fulld is one that neither breathen nor Karrebhl shows other evidence of life after blrth, i Land Berling Carlotte Comment Com 11 -11

|                                                             | DEC 2 3 1930 DEPARTMENT OF PUBL                                                                                                                                                        | IC WELFARE DO NOT WRITE IN THIS SPACE                                                                                                                                                             |
|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PHYSICIAN                                                   | PLACE OF DEATH  County of Cassia CERTIFICATE OF                                                                                                                                        | DEATH                                                                                                                                                                                             |
|                                                             | City of Bully Registration District No                                                                                                                                                 | To a la Demistração No                                                                                                                                                                            |
| EXACTLY.<br>classified.<br>s on back.                       | (If death occurred in a hospital or institution, give Baby Mitchell                                                                                                                    | its name instead of street and number.)                                                                                                                                                           |
| RD.<br>be stated EXA<br>e properly class<br>instructions on | (a) Residence. No.  (Usual place of abode.)  Length of residence in city or town where death occured. yrs. most.                                                                       | ds. How long in U. S. if of foreign birth? yrs. mos. ds.                                                                                                                                          |
| sta<br>sta<br>prope                                         | PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                   | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                      |
| ္ ပို္င္ရွင္မွ                                              | 3. SEX 4. COLOR OR RACE 5. Single, Married, Widowd or Divorced (write the word.)  Finale White Single                                                                                  | 16. DATE OF DEATH  (Month)  (Day)  (Year)                                                                                                                                                         |
| 중 1 원 1                                                     | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                                                                                           | 17. I HEREBY CERTIFY, That I attended deceased from                                                                                                                                               |
| FOR ERMAN ed. A s, so thy y imp                             | 6. DATE OF BIRTH (month, day and year) Nov. 14 1930  7. AGE Years Months Days If LESS than 1 day,                                                                                      | that I last saw had alive on 400 14 1950 and that death occurred, on the date stated above, at 11:00 m.                                                                                           |
|                                                             | 7. AGE Years Months Days If LESS than 1 day, hrs. or Still Born                                                                                                                        | *State the DISEASE CAUSING DEATH, or in leaths from VIOLENT CAUSES. *tate (!) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL. SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH* was as follows: |
|                                                             | 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work                                                                                                            | whether ACCIDENTAL SUICIDAL or HOMICIDAL. The CAUSE OF DEATH* was as follows:                                                                                                                     |
| MARGIN RESE INK—THIS IS Id be carefully DEATH in plain      | (b) General nature of industry, business, or establishment in which employed (or employer)  (c) Name of employer                                                                       |                                                                                                                                                                                                   |
| _ P                                                         | 9. BIRTHPLACE (city or town) Bully, Sa. (State or country)                                                                                                                             | (duration)ds.                                                                                                                                                                                     |
| UNFADING<br>rmation sho<br>CAUSE OF                         | 10. NAME OF FATHER L. S. Mitchell                                                                                                                                                      | (Secondary) (duration) yrs. mos. ds.                                                                                                                                                              |
| TH UP nforms the CAU                                        | 11. BIRTHPLACE OF FATHER (city or town) (State or Country)  Shelling, Oda.  12. MAIDEN NAME OF MOTHER  12. MAIDEN NAME OF MOTHER  13. MAIDEN NAME OF MOTHER  14. MAIDEN NAME OF MOTHER | 18. Where was disease contracted if not at place of death?                                                                                                                                        |
| of i                                                        | 12. MAIDEN NAME OF MOTHER Mylen Carson                                                                                                                                                 | Was there an autopsy?  What test confirmed diagnosis?                                                                                                                                             |
| AINLY<br>y item<br>shoul                                    | 18. BIRTHPLACE OF MOTHER (city or town) (State or County) Dakley, I da-                                                                                                                | (Signed) (Address) R. M. D.                                                                                                                                                                       |
| 180 7<br>TE PLA                                             | Informant Geo. T Mitchell (Address) Burley Ida                                                                                                                                         | 19. Place of Burial, Cremation, or Removal Burley Ida   Date of Burial Nov.14 1930                                                                                                                |
| (87/8<br>WRITE<br>N. B.—I                                   | 15. Filed 16 - 1950 Filed Registrar.                                                                                                                                                   | D.E.Johnson Burley Ida                                                                                                                                                                            |
|                                                             |                                                                                                                                                                                        |                                                                                                                                                                                                   |

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**DUTY OF LOCAL REGISTRARS**—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

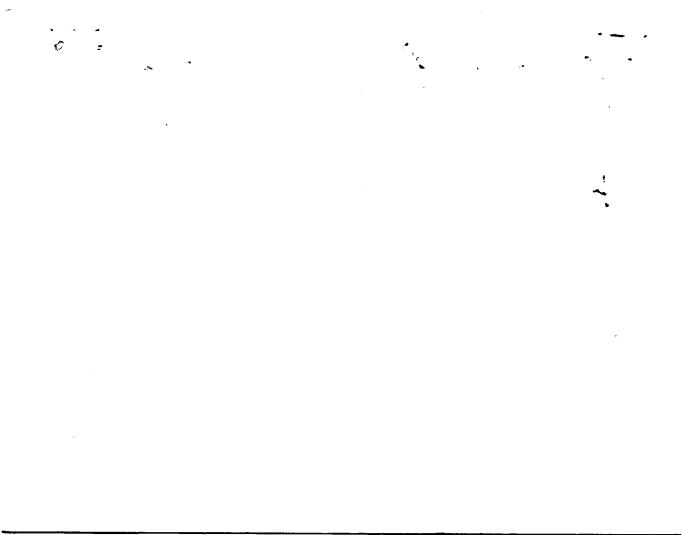
Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE RECORD County BUREAU OF VITAL STATISTICS CERTIFICATE OF BÎRTH ··· Registration District No. 90 PERMANENT State File No..... (If born in hospital or institution Prim. Registration District No. 2/87 Local Registrar's No. 67 give name.) FULL NAME OF CHILD (If stillborn, postitute the word "Stillbirth" for name of child) Number Date of Sex of Legiti-Triplet in order birth Child . or other? of birth (To be answered only in event of plural births) (Month) What prophylactic was used to prevent Ophthalmia Neonatorum?..... Number of child of this mother, including present birth... (a) Born alive and now living. Born alive but now dead... Stillborn FATHER. MOTHER FULL each. MAIDEN Residence (Usual place of abode) Residence (Usual place of abode) If nonresident, give place and State. If nonresident, give place and State. Birthplace Birthplace (City and State or Country) (Offy and State or Country Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* more Born alive ) I hereby certify that I attended the birth of this child, who was ? Stillborn on the date above stated. \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Registrar.



| 70 1                                            | , , , , , , , , , , , , , , , , , , , ,                                           |                                                                                                                   |
|-------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| ŽΥ                                              | STATE OF IDAI  STATE OF IDAI  DEPARTMENT OF PURLI                                 | HO                                                                                                                |
| <b>4</b> 5                                      |                                                                                   | C WELFARE DO NOT WRITE IN THIS SPACE                                                                              |
|                                                 | PLACE OF DEATH BUREAU OF VITAL ST                                                 | ATISTICS                                                                                                          |
| PHYSICIAN<br>of OCCUPA                          | County of Classication CERTIFICATE OF                                             | DEATH State File No. 13212                                                                                        |
| ##                                              | Posistration District No.                                                         |                                                                                                                   |
| 4.5                                             |                                                                                   | T 1 TO - 1 - 1 - 2 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7                                                            |
| 1, X,                                           | Primary Registration District                                                     | No                                                                                                                |
| ECORD<br>EXACTLY,<br>ct statemen                | (No(If death occurred in a hospital or institution, give its                      | )                                                                                                                 |
| RECORD<br>EXACT<br>act state                    |                                                                                   | VP A                                                                                                              |
| EX EX                                           | 2. FULL NAME Gaby not han                                                         | 2,00                                                                                                              |
| RE<br>E                                         |                                                                                   |                                                                                                                   |
| NENT R<br>stated :                              | (a) Residence. No. (Usual place of abode)                                         | St.                                                                                                               |
| tat .                                           | Length of residence in city or town where death occurred. yrs. mos. ds.           | (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.                |
|                                                 |                                                                                   |                                                                                                                   |
| PERMANENT<br>hould be stated<br>y classified. E | PERSONAL AND STATISTICAL PARTICULARS                                              | MEDICAL CERTIFICATE OF DEATH                                                                                      |
| 2                                               | 8. SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word) | 16. DATE OF DEATH                                                                                                 |
| PERI<br>should<br>rly clas                      | Just Indian                                                                       | <u> </u>                                                                                                          |
| rly Bb                                          | 5a. If married, widowed, or divorced                                              | (Month) (Day) (Year)                                                                                              |
| IS A P<br>AGE sho<br>properly                   | HUSBAND of<br>(or) WIFE of                                                        | 17. I HEREBY CERTIFY, That I attended deceased from                                                               |
| AGE<br>prope                                    | (01) WIFE 01                                                                      | , 19, to                                                                                                          |
| Ω                                               | 6. DATE OF BIRTH (month, day and year) Let 13-1930                                | that I last saw h alive on 19                                                                                     |
| rhi<br>gd.                                      | 7. AGE Years Months Days If LESS than 1 day,                                      | and that death occurred, on the date stated above, at /// 2 m.                                                    |
| K—T<br>pplied<br>may<br>cate.                   | hrs. or                                                                           |                                                                                                                   |
| INK—TE<br>supplied.<br>it may<br>tificate.      |                                                                                   | The CAUSE OF DEATH* was as follows:                                                                               |
|                                                 | 8. OCCUPATION OF DECEASED                                                         |                                                                                                                   |
| NG Nully that                                   | (a) Trade, profession, or particular kind of work.                                | Danied Lead                                                                                                       |
| DING<br>efully<br>to tha<br>of ce               | i                                                                                 | Had no fifyer                                                                                                     |
| FADING<br>carefully<br>s, so tha                | (b) General nature of industry,<br>business, or establishment in                  | (duration)yrsmosds.                                                                                               |
| AE<br>Care                                      | which employed (or employer)                                                      | CONTRIBUTORY                                                                                                      |
| ter g                                           | (c) Name of employer                                                              | (Secondary)                                                                                                       |
|                                                 | 611-11 01                                                                         | (duration)yrs,mosds.                                                                                              |
| WITH<br>should<br>plain<br>ction                | 9. BIRTHPLACE (city or town) Shahka daa (State or country)                        | 18. Where was disease contracted                                                                                  |
| E 2 2 3                                         |                                                                                   | if not at place of death?                                                                                         |
| St. is , K                                      | 10. NAME OF FATHER                                                                | Did an operation precede death? Date of                                                                           |
| ITE PLAINLY<br>of information<br>OF DEATH i     | 700000                                                                            | Was there an autopsy?                                                                                             |
| F E¥ 8                                          | 11. BIRTHPLACE OF FATHER (city or town)                                           | What test confirmed diagnosis                                                                                     |
| 7 <u>2</u> 2 3 1                                | (State or Country)                                                                | (Signed) hat of have Carener -                                                                                    |
| 전 '골 <sup>(</sup> 년 년 ]                         | 11. BIRTHPLACE OF FATHER (city or town) (State or Country)                        | 19/13., 19 (Address) Office                                                                                       |
| 1 0 m                                           | 12. MAIDEN NAME OF MOTHER                                                         |                                                                                                                   |
| S E S                                           |                                                                                   | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) |
| WRITE<br>item of i<br>AUSE OF<br>important.     | 13. BIRTHPLACE OF MOTHER (city or town) (State or Country)                        | CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                 |
|                                                 | 14. And Cd.                                                                       |                                                                                                                   |
| er te                                           | Informant MM alams                                                                | 19. Place of Burial, Cremation, or Removal Date of Burial                                                         |
| Every state C is very                           | (Address) allafete                                                                | Uhsahla da Mu 14 19                                                                                               |
|                                                 | 15. 11/12 1/1 A faces                                                             | 20. Undertaker Address                                                                                            |
| N. Bshould                                      | Filed 19 19                                                                       | Madhan Oli.                                                                                                       |
| ZEE                                             | / Registrar                                                                       |                                                                                                                   |

MARGIN RESERVED FOR BINDING

N S12181

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Salesman, (b) Grocery: (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife. Housework. or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH. state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 vrs.) For persons who have no occupation whatever. write None.

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"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure,"
"Hemorrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

DIVISION OF VITAL STATISTICS

## DEPAPEMENT OF COMMERCE BUREAU OF VITAL STATISTICS

LEWIS WILLIAMS SPECIAL ACENT

arthur low

Boise, Idaho.

BIRTH REGISTRATION IS A FARE OF EVERY CHILD'S BIRTHRIGHT. DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE

| _    |    |      |   |
|------|----|------|---|
| DAAT | MA | na r | ۰ |

IDAHO is now in the United States Birth Registration Area and it is essential that birth centificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due time.

| PLACE OF Children born to this mother, including present birth  1. Number of children born to this mother, including present birth  2. Number born alive and now living one girl Nothing  3. Born alive but new dead  4. Number of children stillborn  (Please write rlainly)                                                                                   | FULL NAME OF CHILD Collins out                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| 2. Number born alive and now living one gast total avy 3. Born alive but new dead 4 boys that are dead 4. Number of shildren stillborn                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10.7                                                                                                                                   |
| (Please write plainly)                                                                                                                                                                                                                                                                                                                                          | 2. Number born alive and now living one 3. Born alive but new dead 4 hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | cluding present birth 5                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                 | (Please write rle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ainly)                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ,                                                                                                                                      |
| Information with reference to  FAPHER  South Saper South  (Purification)  Age at last birthday  (Birthplace)  Labor on Rail Raw Section  (Occupation)  Information with reference to MOTHER  MOTHER  MOTHER  MOTHER  MOTHER  MOTHER  (Residence)  Age at last birthday  (Residence)  Age at last birthday  (Eirthplace)  Abor on Rail Raw Section  (Geoupetion) | South | Mrs. Colno Miller Joy<br>(Full Miller Jone)  Chesidence)  Ago at last birthday 26  Chialka Idaho (Birthpiece)  not abil Tiwork Blinder |

Thenking you in advance for your countery in taking care of this matter immediately in order that the report may be completed, I am,

Lewis Williams Special Agent, Rureau of the Census. · · 

| , <u> </u>                                                                                                                                                                                                                  | RECEIVED JAN 7 1931                                                                                                                                                                           | STATE BOARD OF HEALTH FILE NO.                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| and                                                                                                                                                                                                                         | PRECINCT OF                                                                                                                                                                                   | CERTIFICATE OF BIRTH 187230                                                                                        |
| esch,                                                                                                                                                                                                                       | TOWN OR VILLAGE OF                                                                                                                                                                            | A IDAHO                                                                                                            |
| RECORD<br>be made for                                                                                                                                                                                                       | FULL NAME OF CHILD                                                                                                                                                                            | spital or other Institution, give its Name instead of Street and Number)  [If child is not yet named, make]        |
| VT REC                                                                                                                                                                                                                      | SEX OF CHILD OR OTHER?  FULL T:                                                                                             | MATER COA BIRTH 19 19                                                                                              |
| MARGIN RESERVED FOR BINDING WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD of more than one child at a birth, a SEPARATE RETURN must be made mber of each, in order of birth, stated. SEB INSTRUCTIONS ON OTHER |                                                                                                                                                                                               | FULL MOTHER. MAIDEN Cersa M Sright                                                                                 |
|                                                                                                                                                                                                                             | RESIDENCE (USUAL PLACE OF ABODE) CESTA COLOR OR RACE  BIRTHDAY 3                                                                                                                              | RESIDENCE (USUAL PLACE OF ABOUTE) COLOR OR RACE AGE AT LASY BIRTHDAY                                               |
|                                                                                                                                                                                                                             | BIRTHPLACE (CITY OR PLACE)                                                                                                                                                                    | BIRTHPLACE (CITY OR PLACE) Wehnauf                                                                                 |
|                                                                                                                                                                                                                             | (STATE OR COUNTRY)  TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE, AS SPINNER  SAWYER, BOOKKEEPER, ETC.  INDUSTRY OR PUSINESS IN WHICH WORK WAS DONE, AS SILK MILL,  SAWWILL, BANK, ETC. | (STATE OR COUNTRY)  TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE, AS HOUSEKEEPER, TYPIST, NURSE, CLERK, ETC. |
|                                                                                                                                                                                                                             | I NUMBER OF CHILDREN OF THIS MOTHER                                                                                                                                                           | INDUSTRY OR BUSINESS IN WHICH WORK WAS DONE, AS OWN HOME, LAWYER'S OFFICE, SILK MILL, ETC.                         |
|                                                                                                                                                                                                                             | (AT TIME OF THIS BIRTH AND INCLUDING THIS CHILD) (4) BORN ALIVE AND                                                                                                                           | NG BHYGICIAN OR MIDWIFE 5 25                                                                                       |
|                                                                                                                                                                                                                             | *When there was no attending physician or midwife, then the father, householder.                                                                                                              | (SIGNATURE)                                                                                                        |
| WR<br>in case of                                                                                                                                                                                                            | etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.                                                                   | (PHYSICIAN OR MIDWIFE)                                                                                             |
| T<br>ei                                                                                                                                                                                                                     | I GIVEN NAME ADDED FROM SUPPLEMENTAL REPORT                                                                                                                                                   | PHYSICIAN OR MIDWIFE Ogan Plat                                                                                     |
| z                                                                                                                                                                                                                           | , 19 FILED C                                                                                                                                                                                  | 202                                                                                                                |
|                                                                                                                                                                                                                             | REGISTRAR REGISTERED I                                                                                                                                                                        | 10.4.75                                                                                                            |

# Information for Physicians, Midwives, Parents and Others Required to Report Births

#### REPORTS

Section 5051, Compiled Laws of Utah, 1917. That it shall be the duty of the Attending Physician or Midwife to file a certificate of birth, giving all the particulars required by this Act, with the local registrar of the district in which the birth occurred, within ten days after the date of birth. And if there be no attending physician or midwife, then it shall be the duty of the Father of the child, Householder or Owner of the premises, Manager or Superintendent of Institution in which the birth occurred, to file said certificate of birth with the local registrar within three days after the birth,

### EVERY ITEM OF INFORMATION IS IMPORTANT AND MUST BE SUPPLIED

The Full Name of the child is necessary for identification. If the child is not named when the report is made, get a blank from local registrar and make return of name as soon as child is named.

#### DO NOT OMIT ANY FACTS RELATING TO THE PARENTS OF THE CHILD

Section 5055. Compiled Laws of Utah, 1917, provides that: \* \* \* "All Physicians, Midwives, Informants \* \* \* connected with any case, and all other persons having knowledge of the facts, are hereby required to furnish such information as they may possess regarding any birth or death, upon demand of the State Registrar, in person, or by mail, or through the local registrar." \* \* \* The State Registrar will not accept as complete a certificate with this data omitted without satisfactory explanation for failure to report same.

When no physician or midwife attended a birth the persons required to make the report in the order specified in Section 5051 shall strike out the words "I hereby certify that I attended the birth of this child," and write in lieu thereof the words 'No Physician or Midwife," filling out the remainder of the certificate as the law requires and sign as father, householder, etc., as the case may be, with his address.

#### INSTRUCTIONS TO LOCAL REGISTRARS

Read carefully the law relating to the registration of births and do not allow your supply of blanks to become exhausted before requesting more. Carefully examine each certificate as soon as it is filed, and if the facts required by law are not all supplied, return same for complete report, Enter the date of filing in your office immediately; give the certificate its proper registered number and make a copy of the original certificate for your local record. If the name of the child is not reported give the person who made the return a blank for supplemental report of name and direct that it be sent to you as soon as the child is named.

Send all original certificates to the State Board of Health on or before the fifth of the month. If the supplemental report of name of child has not yet been filed, send the certificate and forward the latter report as soon as received after entering name or other fact on your copy. If the child died before being named, the report should be made with the statement "died unnamed."

Section 5059, Compiled Laws of Utah, 1917. And any physician or midwife in attendance upon a case of confinement, or any other person charged with responsibility for reporting births, in the order named in Section 5051 of this Act, who shall neglect or refuse to file a proper certificate of birth with a local registrar, within the time required by this Act, shall be deemed gullty of a misdemeanor. \* \* And any registrar, or deputy registrar, who shall neglect or fail to enforce the provisions of this Act in his district, or shall neglect or refuse to perform any of the duties imposed upon him by this Act or by the instructions and direction of the State Registrar, shall be deemed guilty of a misdemeanor. \* \* \* Any person convicted of a misdemeanor under the provisions of this Act, shall be fined in any sum not less than ten dollars nor more than two hundred dollars,

Blank birth certificates may be obtained from Local Board of Health. Local Registrars or the State Board of Health.

Statement of Occupation.—Make some entry in this section for each parent. For a woman whose only occupation is that of home housework, write housework in answer to first Question and own home in answer to second Question. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper-private family, cook-hotel, etc. For a person who has no occupation whatever write none.

To be complete, an occupation return must state:

The trade, profession, or particular kind of work done.

The industry or business in which the work is done.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory,

mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of occupation can be secured. Do not use the word "mechanic," the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

|                                                                                                                                                                                          | PLA PLA                             |
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| e for                                                                                                                                                                                    | County of                           |
| NT RECORD<br>must be made                                                                                                                                                                | City of                             |
| REC.                                                                                                                                                                                     | No                                  |
| NT                                                                                                                                                                                       | Hospital                            |
| MANE<br>FURN<br>stated.                                                                                                                                                                  | FULL NAM                            |
| WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD—In case of more than one child at birth a SEPARATE RETURN must be made each and the number of each, in order of birth stated. | Sex of<br>Child                     |
| IS A                                                                                                                                                                                     | What bacte                          |
| HIS<br>Ord                                                                                                                                                                               | Number of ch                        |
| F a s                                                                                                                                                                                    | NAME                                |
| birth                                                                                                                                                                                    | RESIDENC                            |
| WRITE PLAINLY WITH UNFADING INK-N. B.—In case of more than one child at birth a cach and the number of each,                                                                             | COLOR                               |
| UNF/                                                                                                                                                                                     | BIRTHPLAC                           |
| ITH<br>Ph on                                                                                                                                                                             | OCCUPATI                            |
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| mor                                                                                                                                                                                      | I hereb                             |
| PLA                                                                                                                                                                                      | cian or n<br>holder, c<br>A stillbo |
| RITE<br>in ca                                                                                                                                                                            | A stillbo<br>breathes<br>life after |
| B K                                                                                                                                                                                      | Give names                          |
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| PLACE OF                              | ERVED IAN 2 19:                                                            | · DELA                                        |                   | FIDAHO PUBLIC WELFAR AL STATISTICS | E                         |
|---------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------|-------------------|------------------------------------|---------------------------|
| City of City                          | luthony                                                                    | * ,                                           |                   | E OF BIRTH                         | $\mathbf{S}_{187259}$     |
| No                                    |                                                                            | on District No                                |                   | State File No.                     |                           |
| Hospital                              | Primary R                                                                  | legistration D                                | istrict No        | Local Registr                      | ar's No                   |
| FULL NAME OF C                        | HILD I                                                                     | · Ru                                          |                   |                                    |                           |
|                                       |                                                                            |                                               | value without     | full name of child.)               |                           |
| Sex of<br>Child                       | Triplet and in o                                                           | mber<br>order<br>birth<br>t of plural births) | Legiti-<br>mate?  | Date Birth<br>(Month)              | (Day) (Year)              |
| 1                                     | olution was used in eyes?                                                  | <u> </u>                                      |                   |                                    |                           |
| FULL NAME William                     | other, including present birth  FATHER  Wardl                              | 10                                            | FULL MAIDEN WANTE | MOTHER<br>2 Jugur                  | · ·                       |
| RESIDENCE PO                          | rkei                                                                       |                                               | RESIDENCE         | arken                              |                           |
| color                                 | age at LAST BIRTHDAY                                                       | (Years)                                       | COLOR             |                                    | AT LAST<br>RTHDAY (Years) |
| BIRTHPLACE                            | 4                                                                          |                                               | BIRTHPLACE        | Salem                              |                           |
| OCCUPATION L                          | cover                                                                      |                                               | OCCUPATION        | forser                             | je                        |
|                                       | CERTIFICATE OF A                                                           | TTENDING                                      | HYSICIAN OF       | R MIDWIFE*                         | G                         |
| on the date above s                   |                                                                            | of this child,                                | who was Stillb    | S O                                | м.                        |
| cian or midwife,<br>holder, etc., sho | as no attending physi-<br>then the father, house-<br>uld make this return. | (Signature)                                   |                   | W.D.                               | 011                       |
| life after birth.                     | ows other evidence of                                                      |                                               |                   | (Physician or midy                 | vife)                     |
|                                       | om a supplemental report.                                                  | Address                                       |                   |                                    | <u>7</u>                  |
|                                       | <b>, 192</b>                                                               | Filed Dec                                     | 3/ 1923           | Now                                | Naus                      |
|                                       | Registrar.                                                                 | _                                             | _                 | V                                  | Registrar.                |

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DEFARIMENT OF COMMERCE BUREAU OF VITAL STATISTICS

LEWIS WILLIAMS SPECIAL AGENT

187339

| TTAL STATISTICS                                                                                                | BUFFAU DR. ALTAIL                                       | STATISTICS                                                    | DIBOTAL ROLL                                  | .14                     |
|----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------|-------------------------|
|                                                                                                                | . *                                                     | Boise, Idaho.                                                 | . JAN 28 1931                                 |                         |
| BIRTH DO YOU                                                                                                   | REGISTRATION IS A F<br>IR DUTT BY YOUR CHIL             | PART OF EVERY (                                               | CHILD'S BIRTHRIGHT.                           | المعقدي أأراء والمعتدين |
| )ear Madam:                                                                                                    |                                                         |                                                               |                                               |                         |
| it is essential that is Kindly fill in the insconvenience. A frankouse in returning the warded you in due time | formation requested envelope, which reame. A government | be made completed below and retrequires no postertificate for | irn at your earliest<br>stage, is enclosed fo | er.<br>or your          |
| FULL NAME OF CHILD                                                                                             | unchris                                                 | tioned                                                        | <u> </u>                                      | <del></del>             |
| PLACE OF HEMA                                                                                                  | DATE OF BIRTH                                           | 17th of                                                       | Now. SEX OF G                                 | och                     |
| 1. Number of children 2. Number born alive 3. Born alive but new 4. Number of children                         | and now living                                          | c, including p                                                | resent birth                                  | enird.                  |
|                                                                                                                | , (Please writ                                          |                                                               |                                               |                         |
| mr Will                                                                                                        | rd D Wa                                                 | rdls.                                                         |                                               |                         |
| Informati <b>ó</b> n<br>FATHE                                                                                  | with reference to                                       | 1                                                             | nformation with refe<br>MOTHER                | rence to                |
| Wilford Del<br>(Full name)                                                                                     | l Hardle                                                | miss                                                          | Vla Viloura<br>(Full MAIDEN name              | Jugn                    |
| Heman Id (Residence)                                                                                           | aho                                                     |                                                               | Heman d                                       | da                      |
| Age at last birthday_                                                                                          | 29 Une                                                  | Ag                                                            | e at last birthday                            | 19 m                    |
| Parker Ido                                                                                                     | J. 7                                                    | 2                                                             | salem de                                      | . //                    |
| (Birthplace)                                                                                                   |                                                         |                                                               | (Birthplace)                                  |                         |
| Lilyt                                                                                                          |                                                         |                                                               | (Occupation)                                  | <del></del>             |
| (Occupation)                                                                                                   |                                                         |                                                               | (00002001011)                                 |                         |
|                                                                                                                |                                                         |                                                               |                                               |                         |
|                                                                                                                | _                                                       |                                                               |                                               |                         |

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Levis Williams

Lewis Williams

Special Agent, Bureau of the Census.

STATE OF IDAHO PERMANENT RECORD E RETURN must be mad DEPARTMENT OF PUBLIC WELFARE County of .... BUREAU OF VITAL STATISTICS City of.... No. .... Registration District No..... (If born in hospital or institution Prim. Registration District No.....Local Registrar's No..... give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of shild) Number Sex of Legiti-Date of Triplet and ₹ in order Child or other? of birth mate? birth ... (To be answered only in event of plural hirths) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth............ (a) Born alive and now living..... FULL MAIDEN Residence (Usual place of abode) Residence (Usual place of abode) It non-resident, give place and State If non-resident, give place and State Color or race... Birthplace (City and State or County) (City and State or County Occupation ... ouse ws CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. Rose uliva I hereby certify that I attended the birth of this child, who was | Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor Address. shows other evidence of life after birth.

DEPARTMENT OF PERLIC USINABLE BEREAU OF VITAL STATISTICS TERRIFUATE ON MINE constitution to institution Prim. Registration District No. ..... Lord Hellstein No. ... PULL NAME OF CHILD elf scillborn, substitute the wain stillbirth for name of evilate Sec. of Fringe and in ord r Date of Legiti-Clobe answered only in zone or denot better Wink prophylicatic was used to prevent Couthains Noonatorpm? Resided of this mother including present bitchers to be a Bern alive and new titles. Brech were tred a little strate ZSCHAV WARES COMMENTS about the mediation of the death of the second of the second tions from the season of the s of the orange over anything and Francicadem, give place and thate property of the contraction Codes the same of the state of the Blothon, Teneral Codes on some of the block firsthphine . . . (City and State, or County) (CILY and State or County). nottakeubad Constitution of the contract o CERTIFICATE OF ATTEMPTS PHYSICIAN OF MIDWITH Lora sittic 1 I bergh; certly that Lattended the birth of this child, who was | Stillborn Evenu the date above stated. Leavent diere nos no attending physician or midwife, then the father, householder, (Paraiclas or inidation ele, should make this return, & stillhorn child is one that neither breathes nor Move other evidence of life after birth.

STATEMENT OF OCCUPATION.—Precise statement of o supation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill: (a) Saleman, (b) Grocery: (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer." etc. without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same ac-

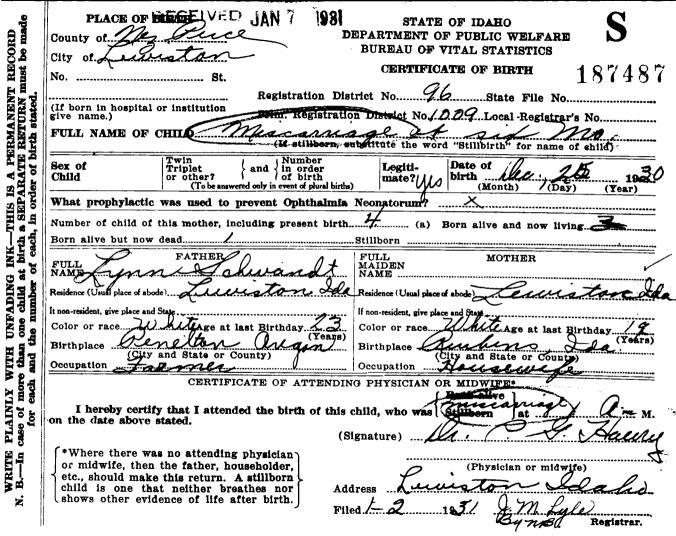
cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidmic cerebrospinal meningitis"): Diptheria (avoid use of "croup"): Typhoid Fever (never report Typhoid pneumonia"): Lobar Pneumonia: Bronchonneumonia ("eneumonia," unqualified is indefite): Tuberculos's of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of ....................... (name origin); "Cancer" is less definite: avoid use of "Tumor" for malignant neoplasms: Measles: Whooping Cough: Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.: Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia." "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident: Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

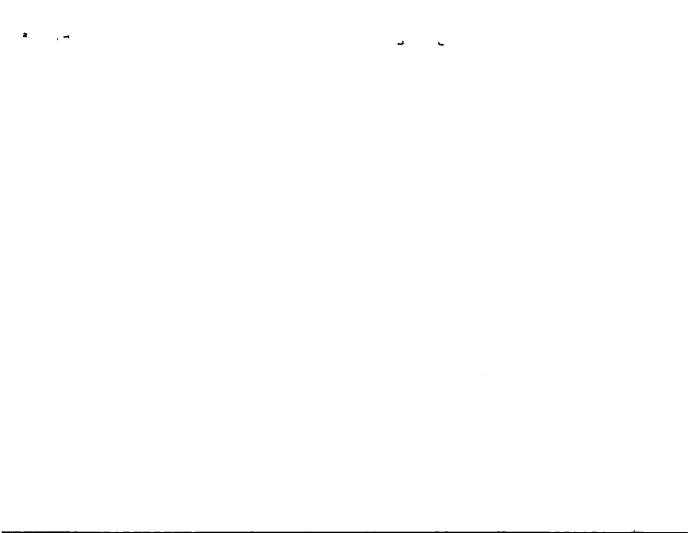
Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.



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STATE OF IDAHO PHYSICIAN: DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH State File No. CERTIFICATE OF DEATH Registration District No..... Local Registrar's No..... Exact statement Primary Registration District No..... stated EXACTLY, Asspital or institution give its hame instead of street and number.) PERMANENT RECORD Residence, No... (If nonresident give city or town and State) (Usual place of abode) How long in U. S., if of foreign birth? Length of residence in city or town where death occurred. yrs. mos. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 16. DATE OF DEATH Single, Married, Widowed, 4. COLOR OR RACE 8. SEX should or (Divorced (write the word) (Day) (Year) 5a. If married, widowed, or divorced HEREBY CERTIFY, That I attended deceased from HUSBAND of AGE (or) WIFE of 6. DATE OF BIRTH (month, day and year) alive on. If LESS than 1 day. 7. AGE Days and that death occurred, on the date stated above, at it may tificate. \_hrs. or The CAUSE OF DEATH\* was as follows: 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry business, or establishment in which employed (or employer) CONTRIBUTORY (c) Name of employer (Secondary) (duration) \_\_\_\_\_yrs. \_\_\_\_mos. \_\_\_ should 9. BIRTHPLACE (city or town 18. Where was disease contracted (State or country) if not at place of death? 10. NAME OF FATHER Did an operation precede death?... Was there an autopsy? 11. BIRTHPLACE OF FATHER (city or What test confirm PARENTS (State or Country) (Signed) item o \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE OF MOTHER (cital or town (State or Country) Cremation, or Removal Date of Burial Informant 19 (Address) Address 20. Undertaker Registrar

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobilé Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

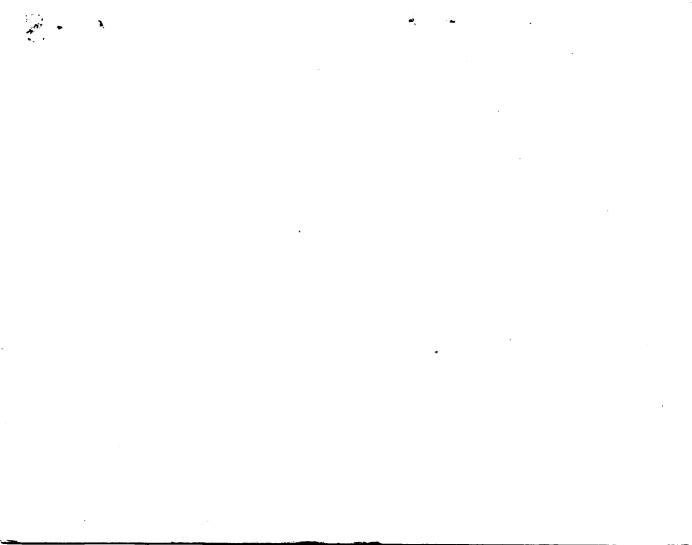
spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
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| . ¥.3                                                                              | STATE OF L                                                                                     | ОАНО                                                                                                                                                          |  |
|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>48</b>                                                                          | TANK 6 1031 DEPARTMENT OF PUI                                                                  | 20 MOT WINTE MY TIME STRONG                                                                                                                                   |  |
| <u> </u>                                                                           | PLACE OF DEATH BUREAU OF VITAL                                                                 | 1 4.5 (0.5)                                                                                                                                                   |  |
|                                                                                    | County of Shoshone CERTIFICATE O                                                               |                                                                                                                                                               |  |
| PHYSICIAN<br>t of OCCURA                                                           | Registration District No                                                                       | /23                                                                                                                                                           |  |
| ent ]                                                                              | City of Colory Primary Registration Distr                                                      | 1.0091 Regigtrar's No. 27 D                                                                                                                                   |  |
| ORD<br>ACTLY,<br>statemen                                                          | (No                                                                                            | ) <b>V</b>                                                                                                                                                    |  |
| AC OR                                                                              | (If death occurred in a hospital or institution, give                                          | its name instead of street and number.)                                                                                                                       |  |
| EXX E                                                                              | 2. FULL NAME DADY Woolf                                                                        | Υ /                                                                                                                                                           |  |
| [ R]<br>ed ]<br>Exa                                                                | (a) Residence. No                                                                              | St.                                                                                                                                                           |  |
| NT ate                                                                             | (Usual place of abode)  Length of residence in city or town where death occurred. yrs. mos.    | ds. How long in U. S., if of foreign birth? yrs. mos. ds.                                                                                                     |  |
| ING PERMANENT RECORD should be stated Exact statemen by classified. Exact statemen |                                                                                                | MEDICAL CERTIFICATE OF DEATH                                                                                                                                  |  |
| G<br>ERMAN<br>uld be<br>classifie                                                  | PERSONAL AND STATISTICAL PARTICULARS  8. SEX   4. COLOR/OR RACE   5. Single, Married, Widowed, | 16. DATE OF DEATH                                                                                                                                             |  |
| Sld SR                                                                             | 8. SEX 4. COLOR/OR RACE 5. Single, Married, Widowed, or Divorced (write the word)              | nov. 12 3                                                                                                                                                     |  |
| ING<br>PERI<br>should                                                              | ovale while single.                                                                            | (Month) (Day) (Year)                                                                                                                                          |  |
|                                                                                    | 5a. If married, widowed, or divorced HUSBAND of                                                | 12, I HEREBY CERTIFY, That I attended deceased from                                                                                                           |  |
| BINI<br>IS AGE                                                                     | (or) WIFE of                                                                                   | $-\parallel \mathcal{W} / \mathcal{V}$ , 19.30, to 19.                                                                                                        |  |
| 13. 15. 15. 15. 15. 15. 15. 15. 15. 15. 15                                         | 6. DATE OF BIRTH (month, day and year) WY 12. 1930                                             | that I last saw hour alive on lead nov /7, 1930                                                                                                               |  |
| FOR Just Lied.                                                                     | 7. AGE Years Months Days II LESS than 1 de hrs.                                                | III and that death occurred, on the date stated above which is to be become                                                                                   |  |
|                                                                                    | Stillborn min.                                                                                 | The CAUSE OF DEATH* was as follows:                                                                                                                           |  |
|                                                                                    | 8. OCCUPATION OF DECEASED                                                                      | Hell Barrier and Aller                                                                                                                                        |  |
|                                                                                    | (a) Trade, profession, or particular kind of work.                                             | the point morner.                                                                                                                                             |  |
| RESERV<br>DING IN<br>efully su<br>to that it                                       | (b) General nature of industry,                                                                | greecence with telampsea.                                                                                                                                     |  |
| RGIN RESE<br>UNFADING<br>be carefully<br>erms, so that                             | business, or establishment in which employed (or employer)                                     | (Secondary)                                                                                                                                                   |  |
|                                                                                    | (c) Name of employer                                                                           |                                                                                                                                                               |  |
| : ⊋: →8                                                                            | (i) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                                      | (duration)yrsmosds.                                                                                                                                           |  |
| WITH<br>WITH<br>should<br>plain<br>ction                                           | 9. BIRTHPLACE (city or town) Clarge,                                                           | 18. Where was disease contracted                                                                                                                              |  |
| ict by W                                                                           | (State or country)                                                                             | if not at place of death?                                                                                                                                     |  |
| LX,                                                                                | 10. NAME OF FATHERY. S                                                                         | Did an operation precede death? Date of                                                                                                                       |  |
| PLAINLY<br>nformation<br>DEATH                                                     |                                                                                                | Was there an autopsy?                                                                                                                                         |  |
| PLAI<br>DEA'<br>See                                                                | 11. BIRTHPLACE OF FATHER (city or town)  State on Quintry)  12. MAIDEN NAME OF MOTHER          | What test confirmed diagnosis?  (Signed) Set Tours M. D.                                                                                                      |  |
|                                                                                    | Salt Jake With wall                                                                            | - Dee 20 1930 (Address Kelloya John                                                                                                                           |  |
| of in OF                                                                           | A 12. MAIDEN NAME OF MOTHER                                                                    | 12001000                                                                                                                                                      |  |
| WRI<br>item c<br>AUSE<br>import                                                    | 10 PYDENIN ACE OF MOTIVEE (ALL PROPERTY)                                                       | *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |  |
| ing v                                                                              | 13. BIRTHPLACE OF MOTHER (cits output)                                                         | whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                                                                                                   |  |
|                                                                                    | 14. MCS MADO                                                                                   | 19. Place of Burial, Cremation, or Removal Date of Burial                                                                                                     |  |
| Eve                                                                                | Informant (Address) (Address)                                                                  | - Kellong Salaha MW 12 1930                                                                                                                                   |  |
| d sis                                                                              | (Audiese)                                                                                      | 20. Undertaker Address                                                                                                                                        |  |
| E E E                                                                              | Filed DEC 28, 1830 hrs. Kless & 73red Registrar                                                | M.C. Thomas in Helemald.                                                                                                                                      |  |
| 7 d F                                                                              | , Registrar                                                                                    |                                                                                                                                                               |  |

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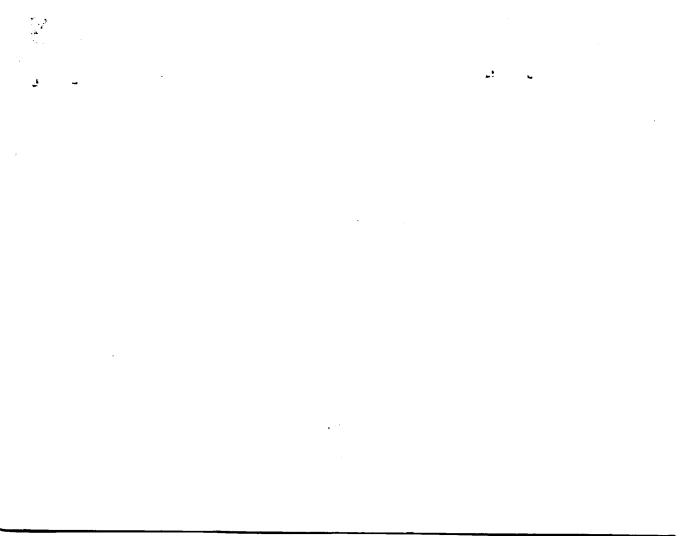
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| -THIS IS A PERMANENT RECORD SEPARATE RETURN must be made for order of birth stated. | County of Letter R. DEPARTME  City of County of Letter R. DEPARTME  City of County of Letter R. DEPARTME  CER  No. St. Registration District N.  (If born in hospital or institution give name.)  FULL NAME OF CHIBD  Twin  Triplet or other?  Child Male  To be answered only in event of plural births) | U OF VITAL STATISTICS 187593  THE NO. State File No |
|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| THIS IS<br>EPARA<br>order of                                                        | Number of child of this mother, including present birth (a) B                                                                                                                                                                                                                                             | Sorn alive and now living                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| INK-<br>birth a<br>ach, in                                                          | FULL Don Ballard NAME NAME                                                                                                                                                                                                                                                                                | MOTHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| UNFADING<br>one child at I<br>number of e                                           | Color or race White Age at last Birthday 24 (Years)                                                                                                                                                                                                                                                       | or race While Age at last Birthday 26 (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| TH<br>han o<br>the                                                                  | Occupation Halistal Country) Occupation Halistal Country                                                                                                                                                                                                                                                  | pation Working Grand State or Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| WRITE PLAINLY WITH<br>N. B.—In case of more than<br>each and the                    | CERTIFICATE OF ATTENDING PHY                                                                                                                                                                                                                                                                              | o was Stillborn at M.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |



| 70.1                                                                 |            | OWNERS OF TRAIN                                                                                         | 70                                                                                                                                      |                                  |
|----------------------------------------------------------------------|------------|---------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| ENT RECORD , stated EXACTLY, PHYSICIANS d. Exact statement of OCCUPA | V          | JAN 6 1931 STATE OF IDAR DEPARTMENT OF PUBLIC                                                           | C WELFARE DO NOT WRITE IN T                                                                                                             |                                  |
|                                                                      |            | PLACE OF DEATH  BUREAU OF VITAL ST  CERTIFICATE OF 1                                                    |                                                                                                                                         |                                  |
| HX                                                                   | Co         | ounty of Jetan CERTIFICATE OF Registration District No                                                  |                                                                                                                                         |                                  |
| nt o                                                                 | Ci         | ty of Schafin Primary Registration District                                                             | O / -/ Tagal Danintuanin M                                                                                                              | . /5                             |
| LY,                                                                  | i          |                                                                                                         |                                                                                                                                         | <b>b</b>                         |
| CT                                                                   |            | (No(If death occurred in a hospital or institution, give its                                            | name instead of street and number.)                                                                                                     |                                  |
| RECORD<br>EXACT<br>act state                                         | 2.         | FULL NAME.                                                                                              | ·                                                                                                                                       |                                  |
| R. Sxa                                                               |            | (a) Residence. No                                                                                       | St                                                                                                                                      | ******                           |
| PERMANENT nould be state                                             | L          | (Usual place of abode) ength of residence in city or town where death occurred. yrs. mos. ds.           | (If nonresident give city or tow<br>How long in U. S., if of foreign birth? yrs.                                                        | n and State) mos. ds.            |
| MANE<br>I be st<br>ssified.                                          |            | PERSONAL AND STATISTICAL PARTICULARS                                                                    | MEDICAL CERTIFICATE OF DEATH                                                                                                            | I                                |
| RM<br>Id l                                                           | 8.         | SEX 4. COLOR OR RACE 5. Single, Married, Widowed, or Privorced (write the word)                         | 16. DATE OF DEATH                                                                                                                       | 0.0                              |
| PERI<br>Should<br>rly clar                                           | ()         | hall While single                                                                                       | (Month) (Day)                                                                                                                           | 19.30<br>(Year)                  |
| <b>⊃&lt;</b>                                                         | 58         | a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                             | 17. I HEREBY CERTIFY, That I attended deceased :                                                                                        | from                             |
| IS AGE prope                                                         |            | (or) WIFE of                                                                                            | 12-14, 1930, to 12-14                                                                                                                   | と 1980                           |
| 113 a                                                                |            | DATE OF BIRTH (month, day and year) Devices   14 -30    AGE Years   Months   Days   If LESS than 1 day, | that I last saw h alive on                                                                                                              | 267 , 19 N                       |
| lied nay                                                             | <b>'</b> ' | hrs. or                                                                                                 | and that death occurred, on that stated above, at 3                                                                                     | , m.                             |
| Supp<br>supp<br>it n                                                 |            | OCCUPATION OF DECEASED                                                                                  | The CAUSE OF DEATH* was as follows:                                                                                                     |                                  |
| S to A to E                                                          |            | (a) Trade, profession, or particular kind of work                                                       |                                                                                                                                         |                                  |
| N KESE<br>FADING<br>carefully<br>8, so that                          |            |                                                                                                         |                                                                                                                                         | /                                |
| S. S                             |            | (b) General nature of industry,<br>business, or establishment in<br>which employed (or employer)        | (duration) yrs.                                                                                                                         | mos. ds.                         |
|                                                                      |            | (c) Name of employer                                                                                    | CONTRIBUTORY (Secondary)                                                                                                                | unbural                          |
| MA<br>TTH<br>vuld<br>ain to<br>on or                                 | -          | bladia                                                                                                  | (duration) yrs.                                                                                                                         | mosds.                           |
| WITH<br>WITH<br>Should<br>plain<br>ction                             | 9.         | State or country)                                                                                       | 18. Where was disease contracted if not at place of death?                                                                              |                                  |
|                                                                      |            | 10. NAME OF FATHER ()                                                                                   | Did an operation precede death? Date of                                                                                                 |                                  |
| PLAINLY formation DEATH                                              |            | Jun Ballara                                                                                             | Was there an autopsy?                                                                                                                   |                                  |
| PLAI<br>form<br>DEA<br>See                                           | NTS        | 11. BIRTHPLACE OF FATHER (city or town) (State or Country)                                              | What test confirmed dischools?                                                                                                          |                                  |
| .= . i                                                               | PARENTS    | Mah                                                                                                     | 12-15-1930 (Address)                                                                                                                    | South L                          |
| WRITE<br>m of i<br>ISE OF                                            | P          | 12. MAIDEN NAME OF MOTHER aska balling                                                                  |                                                                                                                                         |                                  |
| WRI<br>item of<br>AUSE<br>import                                     |            | 18. BIRTHPLACE OF MOTHER (city or town) Os Man                                                          | *State the DISEASE CAUSING DEATH, or in death<br>CAUSES, state (1) MEANS AND NATURE OF II<br>whether ACCIDENTAL, SUICIDAL, or HOMICIDAL | s from VIOLENT<br>NJURY, and (2) |
| 75                                                                   | -          | (State or Country)                                                                                      |                                                                                                                                         |                                  |
| -Every<br>state (<br>is very                                         | 14         | Informant hus John Michell                                                                              |                                                                                                                                         | te of Burial                     |
|                                                                      | _          | (Address) Victor Janho.                                                                                 |                                                                                                                                         |                                  |
| old B                                                                | 18         | Filed 7 10 - 1950 WWW. All Waller                                                                       | zv. Undertaker Add                                                                                                                      | 1res8                            |
| <b>2.45</b>                                                          | <u></u>    | Registrar                                                                                               |                                                                                                                                         |                                  |

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spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of ...... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Chall," "Ulvania," "Washington," "Arabala, "Theories," "Washington," "Arabala, "Theories," "Washington," "Arabala, "Theories," "Washington," "Theories," "Washington," "Asthenia," "Theories," "Washington," "Anaemia," "Old age," "Theories," "Washington," "Theories," "T "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

PLACE OF BIRTH STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS Registration District No..... State File No. (If born in hospital or institution Brim, Registration District No. 2085 Local Registrar's No. 5-2/ give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of shild) Twin Number Date of Legiti-Sex of. Triplet in order birth X Child of birth mate? (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? FULL MAIDEN Residence (Usual place of abode).... If non-resident, give place and State (City and State or County) (City and State or County) Occupation CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. I hereby certify that I attended the birth of this child, who was on the date above stated. (Signature) 2 \*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth. Filed \(\Omega\)

| VITAL STATISTICS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DEPARTMENT C<br>BUREAU OF              |                                                        |                                                       | County of                                  |
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| ALE OR BRIDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                        |                                                        |                                                       | La do vill                                 |
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| Local Registrer's No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | tration District No.                   |                                                        | egital or institution                                 | give name.)                                |
| ed "Sulfiblith" for using of shift)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | en, substitute the we                  | odifice M)                                             | и ог сипр                                             | men Tild                                   |
| tents (Moun)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Legiti-<br>mate?                       | Number i Number in |                                                       | Sex of<br>Calld                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Inila Neonatorum?                      | prevent Ophtha                                         | plactic was used to                                   | What proph                                 |
| Born alive and now living anguer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | dirth, (ii)                            | mineral present                                        | tild of this another, i                               | ly to record                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | stillborn                              |                                                        |                                                       | Horn allye b:                              |
| VOTHER.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 447391<br>2 (4177)                     |                                                        | PATHER                                                | 3.13%                                      |
| The contraction of the first of the contraction of |                                        | mpama or medical                                       | The second second second                              | The same of the                            |
| ebade to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                        |                                                        | beer of abode to and                                  |                                            |
| end Stere                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                        |                                                        |                                                       |                                            |
| T)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ্পত্নৰ সধ্য স্থানিত<br>বিশ্বস্থা       | Lie of the things of the                               | e eght to the second                                  | :a. <b>rolo</b> ()                         |
| city and State or County)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ini. jestodrett<br>(<br>ini. noiveureo | County                                                 | Jo. stets dun steit                                   |                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Nature the Section                     | क्षणकर अस्त अनुसर्वास्                                 | ाँक्ष-१८०० <u>- सिर्</u> केशका वर्षाः<br>भगासम्बद्धाः | nollagary O                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                        |                                                        |                                                       |                                            |
| with arest                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | mara culos lillal, nieli               | ic strict and bule                                     | entte l'esse l'attent                                 | daniit t                                   |
| se maide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | this child, who was                    | to strid ad) bein                                      | r ceclify that I affer<br>above stated.               |                                            |
| sa malistre                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | this child, who was                    | io dirid adi balm                                      |                                                       |                                            |
| sal amiliate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | •                                      | 18 physicien<br>19useholder,                           |                                                       | oa ile ilate<br>[*Where il-<br>[or midwife |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                 |                                                                                               |                                                                                                       | •                                                                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--|
| PHYSICIANS of OCÇUPA-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | - PLACE OF DEATH BUILDING CI                                                                    | STATE OF IDAL<br>RTMENT OF PUBLIC<br>REAU OF VITAL ST.<br>ERTIFICATE OF I<br>tion District No | C WELKAPE ATISTICS DEATH State File N                                                                 |                                                                       |  |
| r RECORD<br>ed EXACTLY, I<br>Exact statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | City of Primary  (No. 1  (If death occurred in a hospit  2. FULL NAME Bales  (a) Residence. No. | Registration District                                                                         | No. 2085 Local Re                                                                                     | gistrar's No2/6                                                       |  |
| etate<br>d. J                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (Usual place of abode)  Length of residence in city or town where death occurred.               | yrs. mos. ds.                                                                                 | How long in U. S., if of foreign birth?                                                               | e city or town and State) yrs. mos. ds.                               |  |
| A A I I I I I I I I I I I I I I I I I I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | PERSONAL AND STATISTICAL PARTIC                                                                 | <del></del>                                                                                   | MEDICAL CERTIFICATE                                                                                   | E OF DEATH                                                            |  |
| ING PERMANENT should be state ily classified. F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 8. SEX 4. COLOR OR RACE 5. Single or Divor                                                      | e, Married, Widowed,<br>ced (write the word)                                                  | 16. DATE OF DEATH                                                                                     | 13 193-0                                                              |  |
| Show of the showing showing showin | 5a. If married, widowed, or divorced                                                            | -gae                                                                                          | (Month)                                                                                               | (Day) (Year)                                                          |  |
| BINDINIS A PAGE shoproperly                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | HUSBAND of<br>(or) WIFE of                                                                      |                                                                                               | 17. I HEREBY CERTIFY, That I atten                                                                    | ded deceased from                                                     |  |
| ID FOR I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. DATE OF BIRTH (month, day and year)                                                          |                                                                                               | that I last saw h alive on                                                                            |                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7. AGE Years Months Days                                                                        | If LESS than 1 day,                                                                           | and that death occurred, on the date state                                                            | , ==                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | X A Y                                                                                           | hrs. or min.                                                                                  | The CAUSE OF DEATH was as follow                                                                      | ·8:                                                                   |  |
| G INK<br>Iy sup<br>hat it                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8. OCCUPATION OF DECEASED                                                                       | • .                                                                                           | Stell born.                                                                                           | **************************************                                |  |
| SE NG E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (a) Trade, profession, or particular kind of work                                               |                                                                                               |                                                                                                       |                                                                       |  |
| RGIN RESUNFADING be carefull erms, so the n. back of of the carefull careful                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (b) General nature of industry, business, or establishment in which employed (or employer)      |                                                                                               | CONTRIBUTORY Sudgestation of Methor                                                                   |                                                                       |  |
| ARG<br>UN<br>L be<br>term<br>on b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (c) Name of employer                                                                            |                                                                                               | (Secondary)                                                                                           | enturis.                                                              |  |
| Y, WITH n should in plain truction o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 9. BIRTHPLACE (city or town) Juin Fall (State or country)                                       | lo Ida                                                                                        | 18. Where was disease contracted if not at place of death?                                            | yrsds.                                                                |  |
| 2 4 5 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10. NAME OF FATHER (Marion S.)                                                                  | lafer                                                                                         | Did an operation precede death?                                                                       | Date of                                                               |  |
| PLAINLY<br>nformation<br>DEATH See inst                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 11. BIRTHPLACE OF FATHER (city or town) (State or Country)  12. MAIDEN NAME OF MOTHER           | laneas.                                                                                       | What test confirmed diagnosis? (Signed)                                                               | <del>пуш</del> , м. р.                                                |  |
| E DE LE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 12. MAIDEN NAME OF MOTHER Sten                                                                  | Lverson                                                                                       | , 19 (Address)                                                                                        | ,                                                                     |  |
| WRITE item of i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 18. BIRTHPLACE OF MOTHER (city or town)                                                         | taho.                                                                                         | *State the DISEASE CAUSING DEAT<br>CAUSES, state (1) MEANS AND NA<br>whether ACCIDENTAL, SUICIDAL, or | H, or in deaths from VIOLENT<br>TURE OF INJURY, and (2)<br>HOMICIDAL. |  |
| Svery<br>tate C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 14. Informant M. S. Rafer. (Address) 337 3rd are n. C.                                          | ·t.                                                                                           | 19. Place of Burial, Cremation, or Remo                                                               | val Date of Burial                                                    |  |
| N. B.—]<br>hould so                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 15. Filed /2/27 , 1930 Cligatity                                                                | Smilly<br>Registrar                                                                           | 20. Undertaker Montuary                                                                               | Address Falls.                                                        |  |
| 4 70 H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 7                                                                                               |                                                                                               |                                                                                                       |                                                                       |  |

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Do not accept a certificate of death signed only by a

midwife.

PLACE OF BIRTH STATE OF IDAHO RECORD be made for DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STANGERY RETURN must by the stated. Registration District No.......3 eu 4 .....State File No..... (If born in hospital or institution Prim. Registration District No. 2085 Local Registrar's No. 5/6 give name.) FULL NAME OF CHILD...... (If stillborn, substitute the word "Stillbirth" for name of child) Number Legiti-Ulo. Date of Sex of Male Triplet in order birth & mate? of birth (To be answered only in event of plural births) (Month) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth (a) Born alive and now living SEP Born alive but now dead\_ Stillborn. MOTHER FATHER FULL MAIDEN NAME C Residence (Usual place of abode) If nonresident, give place and State. If nonresident, give place and State. Age at last Birthday. Age atolast Birthday Color or race. Color or race. (Years) (Years) Birthplace (City and State or County ty and State or Country) Occupation Occupation CERTIFICATE OF ATTENDING PHYSICIAN OF MIDWIFE. I hereby certify that I attended the birth of this child, who was \ Stillborn PLAINLY on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife WRITE etc., should make this return. A stillborn Address child is one that neither breathes nor shows other evidence of life after birth.

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ATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BURGATOF VITAL STATISTICS FICATE OF BIRTH (If horn in hospital Registration District No. 100 Local Registrar's No. give name.) FULL NAME OF CHILD...... (If stillborn, substitute the word "Stillbirth" for name of child) Date of Legiti-/ Sex of in order Triplet and √ birth Child or other? mate2 (To be answered only in event of plural births) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth..... (a) Born alive and now living..... Born alive but now dead..... FATHER FULL Residence (Usual place of abode).... Residence (Usual place of abode)..... If non-resident, give place and Sate, It non-regident, give place and 20te. Color or race/ Color or race Birthplace ......... Birthplace (City and State or County) tate or County) Occupation ..... Occupation ..... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, Physician or mid etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth. Registrar

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|                                                              | _                                                                                      | STATE OF IDA                                               | HO Berell                                                                                                                                                                                        |                                                   |  |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--|
|                                                              |                                                                                        | DEPARTMENT OF PUBL                                         | DO NOT                                                                                                                                                                                           | WRITE IN THIS SPACE                               |  |
| <b>x</b>                                                     | <b> -</b>                                                                              | BUREAU OF VITAL S                                          | TATISTICS                                                                                                                                                                                        | No. 72944                                         |  |
| Ĭ.                                                           | PLACE OF DEATH                                                                         |                                                            | State File                                                                                                                                                                                       | No                                                |  |
| SIC                                                          | County of Ada                                                                          | CERTIFICATE OF                                             |                                                                                                                                                                                                  |                                                   |  |
| PHYSICIAN                                                    | City of Boise                                                                          | Registration District No                                   |                                                                                                                                                                                                  | Yearl Bogistron's No 320                          |  |
| A                                                            |                                                                                        | Primary Registration District                              | No                                                                                                                                                                                               | Local Registrar's No. 320                         |  |
| ₩                                                            | (72. )                                                                                 | (No. St Lukes Hosp                                         | ital.                                                                                                                                                                                            | 10 (mber.) 20 (                                   |  |
|                                                              | (If death or                                                                           | curred in a hospital or institution, give                  |                                                                                                                                                                                                  | •                                                 |  |
| EXACTLY. classified.                                         | 2. FULL NAME Baby Harr                                                                 |                                                            |                                                                                                                                                                                                  |                                                   |  |
| 걸등                                                           | (a) Residence. No. 111. A                                                              | ve. U.                                                     | St. (If non                                                                                                                                                                                      | resident give city or town and State.)            |  |
| erly                                                         | (a) Residence. NoA  (Usual place of abode.)  Length of residence in city or town where | e death occured. yrs. mos.                                 | ds. How long in U. S. if of                                                                                                                                                                      | foreign birth? yrs. mos. us.                      |  |
| RD.<br>be stated<br>e properly                               | PERSONAL AND STATISTIC                                                                 |                                                            | MEDICAL CE                                                                                                                                                                                       | RTIFICATE OF DEATH                                |  |
| ORD<br>be p                                                  | 8. SEX 4. COLOR OR RACE                                                                | 5. Single, Married, Widowed, or Divorced (write the word.) | 16. DATE OF DEATH                                                                                                                                                                                | 2/ 1001/ 31                                       |  |
| . Xell                                                       | Male. White.                                                                           | Single.                                                    | Mill                                                                                                                                                                                             | MON NUC / 6, 1934                                 |  |
| DING<br>F REC<br>should<br>t may                             |                                                                                        |                                                            | 17. I HEREBY CERTIFY, T                                                                                                                                                                          | T attended decase of from                         |  |
|                                                              | HUSBAND of<br>(or) WIFE of                                                             |                                                            | 11                                                                                                                                                                                               |                                                   |  |
|                                                              | 6. DATE OF BIRTH (month, day and year)                                                 | 20.70                                                      |                                                                                                                                                                                                  | , to                                              |  |
| FOR<br>ERM/<br>ed.                                           |                                                                                        | Dec. 16.1930.  Days If LESS than 1 day,                    | that I last saw h alive                                                                                                                                                                          | on, 19                                            |  |
|                                                              | i. AGE legis Montas                                                                    | hrs. or                                                    | and that death occurred, of                                                                                                                                                                      | the date stated above, atm.                       |  |
| RESERVED 1 IS IS A PER fully supplied                        | a accuration of profession                                                             | min.                                                       | CAUSES, state (1) MEANS                                                                                                                                                                          | AND NATURE OF INJURY, and (2) IDAL, or HOMICIDAL. |  |
| ₩ 02 ~ a                                                     | 8. OCCUPATION OF DECEASED (a) Trade, profession, or                                    |                                                            | *State the DISEASE CAUSING DEATH, or in deaths from VIOLEN' CAUSES, *tate (1) MEANS AND NATURE OF INJURY, and (2 whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH* was as follows: |                                                   |  |
| MARGIN RESI<br>INK—THIS I<br>d be carefully<br>EATH in plain | particular kind of work. Non                                                           | 10.                                                        | ALORI                                                                                                                                                                                            | _                                                 |  |
| m 0 _ c                                                      | (b) General nature of industry, business, or establishment in                          |                                                            | NIUN P                                                                                                                                                                                           | on.                                               |  |
| ARGI<br>NK<br>De c                                           | which employed (or employer)                                                           |                                                            |                                                                                                                                                                                                  |                                                   |  |
| MARGIN<br>INK—TI<br>Id be car                                | (c) Name of employer                                                                   | des Table                                                  | ,                                                                                                                                                                                                | duration)yrs,mos,ds.                              |  |
| ~ <sub>#</sub> ##.                                           | 9. BIRTHPLACE (city or town) BO (State or country)                                     | ise, Idano.                                                | ///                                                                                                                                                                                              | iuration,yrsmos.                                  |  |
| DIN<br>of sho                                                | 10. NAME OF FATHER                                                                     |                                                            | (Secondary)                                                                                                                                                                                      | wis ,                                             |  |
| FFA<br>Hon                                                   |                                                                                        | es. M. Harris.                                             |                                                                                                                                                                                                  | duration) yrs. mos. ds.                           |  |
| rmation<br>CAUSE                                             |                                                                                        |                                                            | 18. Where was disease contri<br>if not at place of death                                                                                                                                         |                                                   |  |
| 표월 3.                                                        | (State or Country)                                                                     | VI WWII)                                                   | Did an operation precede dea                                                                                                                                                                     | th? NO Date of                                    |  |
| M M M M M M M M M M M M M M M M M M M                        | 11. BIRTHPLACE OF FATHER (city (State or Country)  12. MAIDEN NAME OF MOTHER           | Mildred Plummer.                                           | Was there an autopsy?                                                                                                                                                                            | no_                                               |  |
| · 유립                                                         | `                                                                                      |                                                            | What test confirmed diagnosis?                                                                                                                                                                   |                                                   |  |
| F                                                            | 18. BIRTHPLACE OF MOTHER (city (State or County)                                       |                                                            | hae 18 1930                                                                                                                                                                                      | (Address) M. D.                                   |  |
| ֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓                        |                                                                                        | Missouri.                                                  |                                                                                                                                                                                                  | 17                                                |  |
| WRITE PLAINL<br>N. B.—Every ite:                             |                                                                                        | arris.                                                     | 19. Place of Burial, Cremati                                                                                                                                                                     | 4/// 45///                                        |  |
| E                                                            | (Address) 111 Ave. C.                                                                  | Boise, Idaho.                                              | 20. Undertaker                                                                                                                                                                                   | Address                                           |  |
| B Z                                                          | 16. Filed 12 - 18 1930                                                                 | W.H. Khoda                                                 |                                                                                                                                                                                                  |                                                   |  |
|                                                              |                                                                                        | Registrar.                                                 | T Summers & Kreb                                                                                                                                                                                 | s. Boise, Idaho.                                  |  |
|                                                              | ••                                                                                     |                                                            |                                                                                                                                                                                                  |                                                   |  |

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REGENTED County of Bonne DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS City of..... CERTIFICATE OF BIRTH RETURN irth stated. (If born in hospital or institution Prime Registration District No.2.155...Local Registrar's No..... give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Number Twin Date of Legiti-Sex of and { in order Triplet birth Child mate? VA or other? (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead..... Stillborn FULL FULL MAIDEN NAME number Residence (Usual place of abode) If non-resident, give place and State. It non-resident, give place and State. Color or race. Birthplace ..... Birthplace ..... (City and State or County) (City and State or County) Occupation ...... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Webuty Registrar.

DEPARTMENT OF PRESIC WELFERTE BUREAU OF THE STATISTICS CERTIFICATE OF REPRIL Louis la gospit is fred I fred I Prime Registration District No. 2.22 Local Resident No. LOUBLE DATE FURN MANE OF CHOLD ... (If soldberg substitute the nord "Stillburt," or name of public, of Triplet and in order legitic bare of triplet of thirds of the constant should bind of the constant should be constant to the constant of the constant should be constant to the constant of the constan That mounts meet to prevent Ophtheima Neonatorum? Complete Complete of stade Recognition aire also earl hair Age at had further Color or race of the following the second statement of the second of the Transfer of the State (NO) and summer of the summer of th CERCIPICATE OF ATTENDENG PHYSICIAN OF VERWER I hereby certify that I attended the birth of this child, who was ( Stiftering to the on the date above stated. istinguist. "Milere Mere was no extending physician " (Physiciation addiction) or addition. Beg, the father, householder, efe should make this return. A stillion. colds a conception political brackless and ान्य राजि अभी के नीति के अनुसन्धित अस्ति है अस्ति है

1930 STATE OF IDAHO RECEIVED NOV PHYSICIAN DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH State File No. 723 CERTIFICATE OF DEATH Donner County of. Registration District No. 76 Local Registrar's No...7.3 Primary Registration District No. 2.155 stated EXACTLY, (No. ..... PERMANENT RECORD (If death occurred in a hospital or institution, give its name instead of street and number.) 2. FULL NAME..... (a) Residence. No.....(Usual place of abode) (If nonresident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. de Length of residence in city or town where death occurred. vrs. mos. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 5. Single, Married, Widowed, or Divorced (write the word) 16. DATE OF DEATH 8. SEX plnoys (Day) (Year) 5a. If married, widowed, or divorced HUSBAND of AGE 17. I HEREBY CERTIFY, That I attended deceased from (or) WIFE of \_\_\_\_\_\_, 19\_\_\_\_\_, to\_\_\_\_\_\_\_, 19 6. DATE OF BIRTH (month, day and year) that I last saw h alive on 19 7. AGE If LESS than 1 day, Davs it may tificate. and that death occurred, on the date stated above, at \_\_\_\_min. The CAUSE OF DEATH\* was as follows: 8. OCCUPATION OF DECRASED (a) Trade, profession, or particular kind of work.... (b) General nature of industry, (duration) \_\_\_\_\_yrs. \_\_\_\_mos. business, or establishment in which employed (or employer) CONTRIBUTORY (c) Name of employer (Secondary) (duration) yrs. mos. ds. 9. BIRTHPLACE (city or town) 18. Where was disease contracted (State or country) if not at place of death? 10. NAME OF FATHER Did an operation precede death?...... Date of DEATH Was there an autopsy? ..... 11. BIRTHPLACE OF FATHER What test confirmed diagnosis? (State or Country) of OF item of ir AUSE OF important. \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18. BIRTHPLACE OF MOTHER (city or town) (State or Country) Place of Burial, Oremation, or Removal Date of Burial state Informant. (Address) Undertake Address

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Do not accept a certificate of death signed only by a midwife.

BUTTELT OF VIENT STATISTICS CERTIFICATION OF BIRCH State File No... Registration District No. Prim Postergelon District No. Local Redetraria No. CITE TAME OF CHILD thilds he established the word "Stillberit" for aster of shift Logitie Sex of ... TURE! exists estaubte (In he say weed only in event of pland both Whee mynnaylarthe was used to prevent Charmains Neonatorung Newton of collection mather, between the form and the above alive and now brank and a second arodili 18 ... Pote affected but now nead. ...... 14943431035 PUBLIC **三月別刊**年8月 Commence of the Commence of th SAME ... Revience Loud olacest abed Residence (Unual place of about ...... William & ..... h nam-recident, give place and state it requirements and the service of the servi ers con con the fact of the st state states more than a part Occumented DISTIPLE ATE OF ATTRIBUTE PHYSHIAM OR MEDWIFE. ( ) Marine ( ) Therein certify that I attended the birth of this child, who was ! Stiffborn on the date shower states. Gegnature) ..... Where there was no attending physician (Physician of until v. e) or midwire, then the father, householder ele, should make this return. A stillborn child is one that neither breathen nor! shows other evidence of life after hirth.

| ed EXACTLY. PHYSICIAN rly classified.                                                                                                                                            | PLACE OF DEATH  PLACE OF DEATH  County of  City | State File No                                                                                                                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| IN RESERVED FOR BINDING THIS IS A PERMANENT RECORD. sacfully supplied. AGE should be stated in plain terms, so that it may be properly PATION is very important. See instruction | PERSONAL AND STATISTICAL PARTICULARS  3. SEX  4. COLOR OR RACE  5. Single, Married, Widowed, or Divorced (write the word.)  5a. If married, widowed, or divorced  HUSBAND of (or) WIFE of  6. DATE OF BIRTH (month, day and year)  7. AGE  Years  Months  Days  If DESS than 1 day, hrs. or particular kind of work  (b) General nature of industry, business, or establishment in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | MEDICAL CERTIFICATE OF DEATH  16. DATE OF DEATH  (Month) (Day) (Year)  17. I HEREBY CERTIFY, That I attended deceased from  19, to                                                                                                                                                                         |
| WRITE PLAINLY, WITH UNFADING INK-THIS IS N. B.—Every item of information should be carefully N. B.—Every should state CAUSE OF DEATH in plain Exact statement of OCCUPATION      | which employed (or employer)  (c) Name of employer  9. BIRTHPLACE (city or town)  10. NAME OF FATHER  11. BIRTHPLACE OF FATHER (city or town)  (State or Country)  12. MAIDEN NAME OF MOTHER (city or town)  (State or Country)  14. Informant (Address)  15. Filed. Acc. 4 19 30 Registrar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (duration) yrs. mos. ds.  CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.  18. Where was disease contracted if not at place of death? Date of. Was there an autopsy?  What test confirmed diagnosis? (Signed) , M. D.  19. Place of Burial, Cremation, or Removal Date of Burial  20. Undertaker Address |

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., Farmer, Physician, Stenographer. Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc, without more precise specifications, as Day laborer. Farm laborer. Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidmic cerebrospinal meningitis"); Diptheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia"); Lobar Pneumonia; Bronchopneumonia ("pneumonia," unqualified, is indefite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of ...... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping Cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

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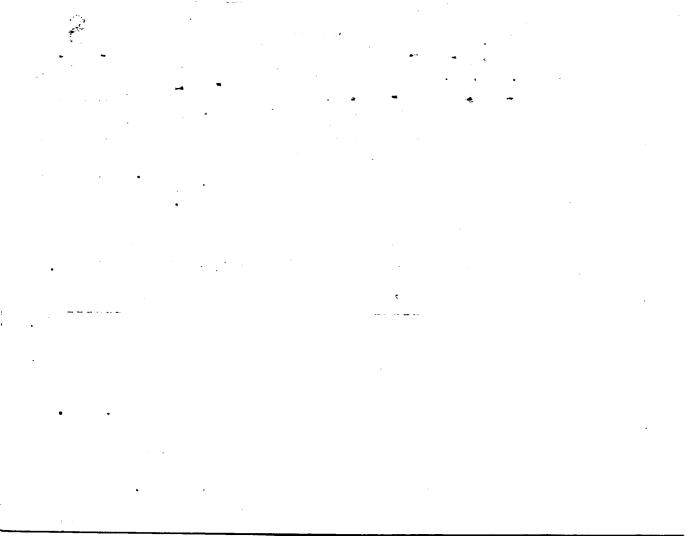
WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD N. B.—In case of more than one child at birth a SEPARATE RETURE must be made for each and the number of each, in order of birth stated.

| PLACE OF BIRTH                                                                       | _ STATE OF IDAMS                                    |
|--------------------------------------------------------------------------------------|-----------------------------------------------------|
| County of Jakak                                                                      | EPARTMENT OF PUBLIC WELFARE                         |
| 73024                                                                                | BUREAU OF VITAL STATISTICS                          |
| City of RECEIVED JAN 9 1                                                             | CERTIFICATE OF BIRTH 188183                         |
| No. St.                                                                              |                                                     |
|                                                                                      | rict No. 44 State File No. 8                        |
| (If born in hospital or institution give name.)  Prim. Registratio                   | n District No2/45 Local Registrar's No              |
| FULL NAME OF CHILD                                                                   | m/                                                  |
|                                                                                      | ibstitute the word "Stillbirth" for name of child)  |
| Twin Number                                                                          |                                                     |
| Sex of Triplet and in order of birth (To be answered only in event of plural births) | Legiti- mate?  Mate of 700-18  (Menth) (Day) (Year) |
| What prophylactic was used to prevent Ophthalmia                                     |                                                     |
| Number of child of this mother, including present birth.                             | 3 (a) Born alive and now living                     |
| Born alive but now dead                                                              | Stillborn                                           |
| FULL Harry Enoch Tracy                                                               | MAIDEN Helda Ruth Lines                             |
| Residence (Usual place of abode).                                                    | Residence (Usual place of abode)                    |
| It non-resident, give place and State.                                               | If non-resident, give place and State               |
| Color or race bhile Age at last Birthday 37                                          | Color or race. While Age at last Birthday 26        |
| Birthplace Ores (Years)                                                              | Birthplace Deary (Years)                            |
| (City and State or County)                                                           | (City and State or County)                          |
| Occupation Washington                                                                | Occupation                                          |
| CERTIFICATE OF ATTENDIN                                                              | IG PHYSICIAN OR MIDWIFE.                            |
|                                                                                      | Born alive                                          |
| I hereby certify that I attended the birth of this                                   | child, who was stillborn at 4 - 10 Q M.             |
| on the date above stated.                                                            | ignature) A. B. Poero                               |
|                                                                                      | TM S                                                |
| *Where there was no attending physician or midwife, then the father, householder.    | (Physician or midwife)                              |
| etc., should make this return. A stillborn                                           | C - 10 E Internal                                   |
|                                                                                      | dress Bootle, Tac.                                  |
| shows other evidence of life after birth.                                            | ed Nov- 2/1,30 E. B. Hacker                         |
| FIL                                                                                  | Registrar.                                          |

MANU TO TRAVERSE Residentian District No. 200 State Ede No. 1 Petro Region of therest and A. S. Local Region of the TI NAME OF CHIEF If stillbare, substilute the well "Millattle for mane of childy The second of th In aller What prophylactic was used to present Ophtralian Acoustics at mention of child of the modifier induling present title. I. . . . . . . . Earl allocated new trivers torn after that now thend a laft a limit SSRTIT The state of the s and the state of the state of the companion of the state Color or the Atlantic Are at less strader with the color of terms of Social architecture at the trader and at Fringlace or County) countries de la constant de la const CERTIFICATE OF ACTEL OWN DEVSTORY OR MIDWERS. I will a most i knowebs certify that I attended the birth of this child, who was i millions. " on the date above stated." E. A. L. (SEPERIORIE) f\*Where there was no attending physician or midwife, then he rather himsemblder, seen, should night this relief, Aveiliberth REGULESH. child is one that neither traction nor the other orideness of lefe after birth.

STATIRE GEWED FEB 1 4 19 PLACE OF BURTH DEPARTMENT OF PUBLIC WELFARE PERMANENT RECORD County of BUREAU OF VITAL STATISTICS 188205 CERTIFICATE OF BIRTH State File No..... Registration District No...... (If born in Kospital or institution Local Registrar's No..... give name.) FULL NAME OF CHILD. (If stillborn, substitute the word "Stillbirth" for name of child) Number Twin Date of Legiti- a. Sex of in order Triplet birth / mate? Child MA or other? (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead......Stillborn FULL MAIDEN NAME Residence (Usual place of abode) Residence (Usual place of abode) If non-resident, give place and state It non-resident, give place and State .....Age at last Birthday..... Color or race..... Birthplace .... Birthplace ..... (City\and State or County) (City and State or County) Occupation ..... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* Dozn alive I hereby certify that I attended the birth of this child, who was Stillboza on the date above stated. (Signature) \*Where there was no attending physician (Physician or midwife) or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor 1931 Clis Belland shows other evidence of life after birth.

HAGISHO STOP PLACE OF BIRTH DER CONSING OF PURISO WEE County of .... THE AU OF VITAL STATISTICS HTIBE WO BIADISTI noisulitent an Institution are institution Prim. Registration Discret No. ..... Local Redsires No. ....... idrette and in order 10 000 foller) (To be answered only in mone of allors bushes What prophylactic was used to prevent Ophthalmia Neonatorum? Number of chile, a the worldest including present lighth. . . . . . . . (a) Born olive and now living. . . . . MARTIN. Color or race . . . . Age at last Birthday .....Age at last Birthony ........ (YOUTS) or ity and State or County) CERTIFICATE OF AFTENDING PHYSICIAN OF MIDWIFE. I beiseby certify that I attended the blith of this child, who was Stillborn on the date above statistic (Signature) .... swhere there was no attending physician't (Physician or midwife) ownidwife, then the father, householder, eff should nake this return. A stillborn Address child is one that neither breathes nor shows hither evidence of His after birth. bsh'd



Theodore Ed. Newton

Payette, Id

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PLACE OF BIRTH RECEIVED

JAN 17

CERTIFICATE OF BIRTH

4. State F DEPARTMENT OF PUBLIC WELFARE County of PAYETTE. BUREAU OF VITAL STATISTICS City of..... SEPARATE RETURN must Registration District No. 4. State File No. (If born in hospital or institution Prim. Registration District No. 1008. Local Registrar's No. 1 give name.) Stillbirth. IIDIPUN.

(If stillborn, substitute the word "Stillbirth" for name of shild) FULL NAME OF CHILD..... birth Twin Number Date of Dec. 24,1930.19 in order Legiti-Sex of Triplet mate?Yes birth or other? of birth Child Male (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? ... None. Number of child of this mother, including present birth.......... (a) Born alive and now living O Born alive but now dead Stillborn birth MOTHER FATHER FIILL MAIDEN Welsie Creech. FULL David Sesena. NAME Residence (Usual place of abode) Pavette Idaho Residence (Usual place of abode) Pavette. Idaho... If non-resident, give place and State It non-resident, give place and State Color or race White Age at last Birthday CYears) Color or race White Age at last Birthday 21. Oregon Birthplace ..... than Birthplace ...... (City and State or County) CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. Stillborn Born alive I hereby certify that I attended the birth of this child, who was Stillborn ö on the date above stated. Case (Signature) \*Where there was no attending physician or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn Payette. Idaho. Address child is one that neither breathes nor shows other evidence of life after birth.

COLUMN TO THE ASSESSMENT HEPARTHEY OF HALL STATE OFF PERSON SO YESTER SE SUR STAR MANAGEMENT OF THE STREET the trees out to make after The effect of the test of the sense of the feet the feet and the feet and the first the sense of the contract of Grown Company (Which are the company) and the company of the compa to see When pupply badic and eved to preient confidence Francis and MODO. Surviver of child of the section, and other research in the said there along and now trong 12. 产人使用更高。 Rains on the contract of the second Wortene. commercial destruction all THE PROPERTY OF THE PROPERTY OF THE PARTY OF THE PROPERTY OF T APPERS ONLY WORK The condition with the third out this chile, and who will be the state of the condition of ten the then about states Part there there was no allegaling my sician Tallachine in aginigenin or midwire, then the father, householder, ote, should atome the rejure. A stillborn AND THE PROPERTY OF THE PROPERTY OF THE PARTY OF THE PART which is one that delities breathes nor about officer evidence of life after hirth.

sed e Woodward RECECUTIficate of Death Oregon State Board of Health 1. PLACE OF DEATH State Registered No..... Local Registered No. Township (If death occurred in a hospital or institution, give its name instead of street number) da/How long in U. S., if of foreign birth? Length of residence in city or town where death occurred 2. FULL NAME ... (a) Residence: No...... Z......St. ....... (If nonresident, give city or town and state) (Usual place of abode) PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH 8. SEX Single, Married, Widowed or 21. DATE OF DEATH (month, day, and year divorced (write the word) FOR BINDING I HEREBY CERTIFY, That I attended If married, widowed, or divorced HUSBAND of (or) WIFE of to have occurred on the date stated above, at 6. DATE OF BIRTH (month, day, and year) -2 The principal cause of death and related causes or importance in order If less then 7. AGE Dave Date of onset 1 day. ... hrs. or .... min. 8. Trade, profession, or particular OCCUPATION kind of work done, as spinner. sawyer, bookleeper, etc. 9. Industry or business in which work was done, as silk mill. sawmill, bank, etc. Contributory causes of importance not related to principal 10. Date deceased last worked 11. Total time (years) cause: spent in this at this occupation (month and year)..... occupation ..... 12. BIRTHPLACE (city or town) (State or country) 18. NAME What test confirmed diagnosis?..... Was there an autopsy?\_\_\_\_\_ 14. BIRTHPLACE (city or town) instructions 28. If death was due to external causes (violence) fill in also the fol-(State or country) lowing: 15. MAIDEN NAME Accident, suicide, or homicide?..... Date of injury ...... 19 Where did injury occur? ...... 16. BIRTHPLACE (city or town) (Specify city or town, county, and state) Specify whether injury occurred in industry, in home, or in public place. (State or country 17. INFORMANT Manner of injury DEATH (Address) plnods mportant. Nature of injury 18. BURIAL, CREMATION OR REMOVAL 24. Was disease or injury in any way related to occupation of deceased? Hon ..... If so\_specify OF 19. UNDERTAKER (Address) (Signed)

## UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed on account of the disease causing death, report the occupation prior to illness. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as house-keeper—private jamily, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8. The trade, profession, or particular kind of work done.
- 9. The industry or business in which the work was done.
- The month and year the deceased last worked at the occupation.
   The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employe," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kind of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under contributory causes of importance not related to principal cause, name other important diseases or injuries. Examples:

## : Example I

The principal cause of death and related causes of importance in order of onset were Date of onset as follows:

| Arteriosclerosis                                                       | 1915                                    |
|------------------------------------------------------------------------|-----------------------------------------|
| Chronic interstitial nephritis                                         | 4004                                    |
| Cerebral hemorrhage                                                    | July 5, 1927                            |
|                                                                        | *************************************** |
| Contributory causes of importance not re-<br>lated to principal cause: |                                         |
| Fracture of arm                                                        |                                         |
| Automobile accident                                                    | May 3, 1927                             |
|                                                                        | *************************************** |

## Example II

The principal cause of death and related causes of importance in order of onset were Date of onset as follows:

| Attack of epilepsy                                                     | 1 week ago                              |
|------------------------------------------------------------------------|-----------------------------------------|
| Run over by street car                                                 |                                         |
| Peritonitis                                                            |                                         |
|                                                                        | *************************************** |
| Contributory causes of importance not re-<br>lated to principal cause: | *************************************** |
| Influenza                                                              | 6 weeks ago                             |
|                                                                        |                                         |

In a group of causes containing the principal cause and related causes, the causes should be given in the order of onset, so that in a group of three causes the principal cause may appear in either first, second, or third position. The principal cause in each of the above examples happens to be the second cause given.

| Additional | Space | for | Further | Statements | by | Physician |
|------------|-------|-----|---------|------------|----|-----------|
|            |       |     |         |            |    |           |

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE County of Layette. BUREAU OF VITAL STATISTICS City of Sutte CERTIFICATE OF BIRTH 188305 No. ..... (If born in hospital or institution Prim. Registration District No. A.Local Registrar's No... give name.) FULL NAME OF CHILD..... (If stillborn, substitute the word "Stillbirth" for name of child) Number Twin Date of Legiti-Sex of in order Triplet and mate?// birth ...& Child ~ or other? (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Born alive but now dead Stillborn FULL MAIDEN FULL Residence (Usual place of abode) Laurelle If pon-resident, give place and State It non-resident, give place and S Color or race White Age at last Birthday Birthplace Mun City and State or County) Occupation Assessment CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. Rorn alive I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. \*Where there was no attending physician? or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn Address assette & Adaho. 1 child is one that neither breathes nor shows other evidence of life after birth.

THE THINK DEPARTMENT OF EURLIC WEEK ALLEY OF VITAL STATISMEN State Pile the Registrating Mariet Vantages. Print Heater Allow District No. - In Local Registrate Mo. VELL MANE OF CHILD.... iff suffered nubstitued the word "Sellibirity for name of stilles Putte of Tours Wit DES mate? (Middle) To be sentened only to eventual plure in the Number of child in his a citien melighing propert with ...... (4) Born sires and new Menge..... . hash wor but make door 1.1717 MEDIA Colored the sale was a series of lest 100 miles Occupation property SECRETARIOR OF ATTEMPTATE ON ALD THE SECTION OF ALD TREES Borts alleg I becely certify that I aftended the birth of this child, who was Selliborn on the teste above states. "" When the a was no strending physican, clery sician arenderits of militale, then the father, house holder. to should make this return. A miliboru ros medier breither breathen nor town prince evidence of life after birth.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH 188966 Registration District No.....State File No..... (If born in a spital or institution Prim. Registration District No.....Local Registrar's No... FULL NAME OF CHILD... (If stillborn, substitute the word "Stillbirth" for name of child) Twin Number Sex of Legiti-Date of Triplet in order Child mate? 74 birth .... or other? (To be answered only in event of plural births) (Month (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth. (a) Born alive and now living. Born alive but now dead O Stillborn FULL MAIDEN It non-resident, give place and State If non-resident, give place and State. Birthplace ..... (City and State or County) Occupation ... CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\* I hereby certify that I attended the birth of this child, who was | Stillborn on the date above stated. (Signature) \*Where there was no attending physician recare! or midwife, then the father, householder, (Physician or midwife) etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

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RECEIVED OCT 6 STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE DO NOT WRITE IN THIS SPACE BUREAU OF VITAL STATISTICS PLACE OF DEATH CERTIFICATE OF DEATH State File No..... County of... Registration District No. 12.3 Exact statement of Local Registrar's No..... City of ..... Primary Registration District No. 230/ RECORD 2. FULL NAME..... (a) Residence. No..... PERMANENT (If nonresident give city or town and State) (Usual place of abode) How long in U. S., if of foreign birth? ds. yrs. mos. Length of residence in city or town where death occurred. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 16. DATE OF DEATH 5. Single, Married, Widowed, or Divorced (write the word) S. SEX 4. COLOR OR RACE should mue (Month) (Day) (Year) 5a. If married, widowed, or divorced HUSBAND of I, HEREBY CERTIFY, That I attended deseased from (or) WIFE of 193 6. DATE OF BIRTH (month, day and year) If LESS than 1 day, 7. AGE Months Davs Years and that death occurred, on the date stated above, at..... ...hrs. or The CAUSE OF DEATH\* was as follows: 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in (duration) \_\_\_\_yrs. \_\_\_mos. \_\_\_ which employed (or employer) CONTRIBUTORY (c) Name of employer (Secondary) (duration) should 9. BIRTHPLACE (city or town) Where was disease contracted if not at place of death? (State or country) 10. NAME OF FATHER Did an operation precede death?... Date of Was there an autopsy? ...... 11. BIRTHPLACE OF FATHER (city or town What test confirmed diagnosis? (State or Country) 12. MAIDEN NAME OF MOTHER impor \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 13. BIRTHPLACE OF MOTHER (city or (State or Country) tate ( Place of Burial, Cremation, or Removal Date of Burial Informant. ŒŒ. (Address) Address 20. Undert Registrar

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases. especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever. write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse,"
"Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a

midwife.

PLACE OF BIRTH 8/3/21/ County of Bennock 003-557 DEPARTMENT OF PUBLIC WELFARE HIS IS A PERMANENT RECORD SEPARATE RETURN must be main order of birth stated. BUREAU OF VITAL STATISTICS City of Pocatello CERTIFICATE OF BIRTH No.St Anth cny St.  $\sim 189124$ Registration District No. 28 State File No. Hosp (If born in hospital or institution Prim. Registration District No. 2/6/ Local Registrar's No. 10,15) give name.) FULL NAME OF CHILD Stillborn Hatch (If stillborn, substitute the word "Stillbirth" for name of child) and in Twin Legiti- ye birth 12/11/30/ Sex of Triplet Child Female or other? of hirth (To be answered only in event of plural births) (Month) (Day) (Year) What prophylactic was used to prevent Ophthalmia Neonatorum? .Neo-Silvol Born alive but now dead \_\_\_\_\_\_\_ Stillborn \_\_\_\_\_\_ FATHER FULL MOTHER NAME Simmons F. Hatch MAIDEN Tressa England UNFADING one child a Residence (Usual place of abode) Robin Idaho Residence (Usual place of abode) Robin Idaho It non-resident, give place and State..... If non-resident, give place and State\_\_\_\_\_ Color or race....W.........Age at last Birthday. 40 Birthplace Franklin Utah
(City and State or County)
Occupation Farmer Birthplace Plain City Utah (Years)
(City and State or County) WITH Occupation H.W. more each a CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. PLAINLY Born allve case of on the date above stated. (Signature) WRITE B.—In \*Where there was no attending physician or midwife, then the father, householder, (Physician-or midwife etc., should make this return. A stillborn child is one that neither breathes nor Address shows other evidence of life after birth.

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## STATE OF IDAHO

DEDADTMENT OF DURING WELFARE

|            | Mr. C. C. C. |
|------------|--------------|
| te Vile No | 72988        |

| DEPARIME | TA T          | OF | FOL | PILO | AA ETH. WIC |
|----------|---------------|----|-----|------|-------------|
| BUREAU   | $\mathbf{OF}$ | VI | ΓAL | STA  | TISTICS     |

|         |            | CERTHICATE OF DEATH      |   |
|---------|------------|--------------------------|---|
| County  | of Bannock | CERTIFICATE OF DEATH     | , |
| City of | Pogatello  | Registration District No |   |

Local Registrar's No. 5957

DECEIVED IN 18

Primary Registration District No. 2161 (No St. Anthony Hospital

(If death occurred in a hospital or institution, give its name instead of street and number.)

| 2. | FULL NAME Infant         | Hatch                                   |     | RECEIVED INN 10 1831                         |
|----|--------------------------|-----------------------------------------|-----|----------------------------------------------|
|    | (a) Residence, No. More. | land Idaho                              | St. | 204                                          |
|    | (Usual place of shode)   | *************************************** |     | (If nonresident give city or town and State. |

How long in U. S. if of foreign birth? mos. Length of residence in city or town where death occured. mos. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 8. SEX 4. COLOR OR RACE Widowed. Single, Married, 16. DATE OF DEATH or Divorced (write the word.) White Female

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

PLACE OF DEATH

- 6. DATE OF BIRTH (month, day and year) December 11.1930
- 7. AGE Years Months If LESS than 1 day, Days ().....hrs. or O 0 O
- 8. OCCUPATION OF DECEASED
- (a) Trade, profession, or None

particular kind of work.....

- (b) General nature of industry. business, or establishment in which employed (or employer)
- (c) Name of employer
- Pocatello Idaho 9. BIRTHPLACE (city or town).. (State or country)
  - 10. NAME OF FATHER Hatch S.F.
- 11. BIRTHPLACE OF FATHER (city or town)..... (State or Country) Utah
- PARENTS Tressa England 12. MAIDEN NAME OF MOTHER
  - 18. BIRTHPLACE OF MOTHER (city or town) ....
- S.F. Hatch Informant (Address)
- Filed 12/12/30 19\_

(State or County)

| December , (Month)                                                                                                    | 11 1930<br>(Day)                      |             |
|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------|
| 17. I HEREBY CERTIFY, That                                                                                            | I attended deceased from              | n           |
| J., 19                                                                                                                | ., to                                 | 19          |
| that I last saw h alive on.                                                                                           | 1777790                               | 19          |
| and that death occurred, on the                                                                                       | he date stated above, a               | t           |
| *State the DISEASE CAUSING<br>CAUSES, state (1) MEANS AT<br>whether ACCIDENTAL, SUICIDA<br>The CAUSE OF DEATH* was as | ND NATURE OF INS<br>AL, or HOMICIDAL. | UKI, BIR (2 |
| · Mil moder                                                                                                           | O LISTER                              | see and     |
| Lyw Sweng                                                                                                             | my door                               |             |
| ebant 10 days                                                                                                         |                                       | evry        |
| /                                                                                                                     | ation)yrs                             |             |
| CONTRIBUTORY                                                                                                          |                                       |             |

\_\_\_\_\_\_(duration) \_\_\_\_\_yrs. \_\_\_\_mos. \_\_\_\_

19. Place of Burial, Cremation, or Removal

Moreland Idaho 20. Undertaker

(Secondary)

Arthur W. Hall

18. Where was disease contracted if not at place of death?

Did an operation precede death?

What test confirmed diagnosis?

Was there an autopsy?.

Address

Date of Burial

Poca. Idaho

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer. Stationary fireman, etc. But in many cases, especially in industrial employments it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery: (a) Foreman. (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager." "Dealer," etc. without more precise specifications, as Day laborer Farm laborer. Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife. Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 vrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same ac-

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DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

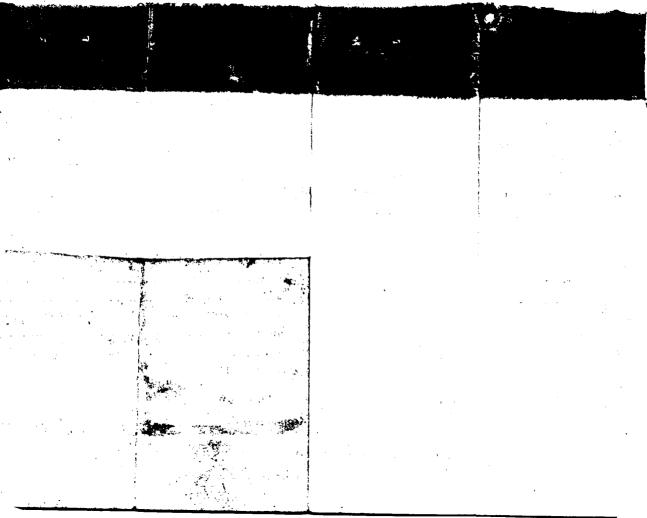
Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

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Do not accept a certificate of death signed only by a midwife.

|                                                                   | COMMUNICATION OF THE CONTRACT  |
|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                   | 16. 743 So. 374 st.  16. 743 So. 374 st.  16. 743 So. 374 st.  16. 743 So. 375 st.  16. 745 st |
| PERMANE<br>TE RETUR<br>I birth stat                               | give name.)  Prim. Registration District No. Local Registrar's No. 15  FULL NAME OF CHILD Still virty Druce (If stillborn, substitute the word "Stillbirth" for name of child)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| THIS IS A PERMANH<br>a SEPARATE RETUR<br>, in order of birth stat | Sex of Child Twin   Number in order of birth   Legiti-   Date of birth   Date of birth   Month   Day   (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| EP/                                                               | What prophylactic was used to prevent Ophthalmia Neonatorum?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| a SEI                                                             | Number of child of this mother, including present birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| IK—T<br>irth a<br>each,                                           | Born alive but now lead                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| of p                                                              | FULL A MAIDEN CLEY MAIDEN CLEY MANDEN CONTROL NEWS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| ADINC                                                             | Residence (Usual place of abode) The selection of the Residence (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| ch                                                                | It non-resident, give place and state                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| UNFADING n one child a the number                                 | Color or race (Years)  Risthalogo Birthalogo Birthalogo Birthalogo Birthalogo Birthalogo Color or race (Years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| than<br>and ti                                                    | (City, and State or County)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| > ~ ~                                                             | Occupation Occupation Occupation  CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| PLAINLY W case of more for each s                                 | I hereby certify that I attended the birth of this child, who was stated.  (Signature)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| wRITE P. N. B.—In ca                                              | *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.  *Address*  Address*  Filed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



STATE OF IDAHO DO NOT WRITE IN THIS SPACE DEPARTMENT OF PUBLIC WELFARE PHYSICIAN BUREAU OF VITAL STATISTICS PLACE OF DEATH State File No. . CERTIFICATE OF DEATH Registration District No. ..... Local Registrar's No. Primary Registration District No. 2161 (If death occurred in a hospital or institution, give its name instead of street and number.) (a) Residence. No. (If nonresident give city or town and State.) (Usual place of abode.) How long in U. S. if of foreign birth? mos. yrs. Length of residence in city or town where death occured. mos. L ds. MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS 3. SEX 5. Single, Married, Widowed, 4. COLOR OR RACE 16. DATE OF DEATH or Divorced (write the word.) (Month) 5a. If married, widowed, or divorced 17. LHEREBY CERTIFY, That I attended deceased from HUSBAND of (or) WIFE of 6. DATE OF BIRTH (month, day and year) that I last saw home, alive on and that death occurred, on the date stated above, 7. AGE EESS than 1 day. Years Months hrs or \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. The CAUSE OF DEATH\* was as follows: annemin. 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Mone (b) General nature of industry, business, or establishment in which employed (or employer) ..... (c) Name of employer \_\_\_\_\_(duration) \_\_\_\_\_yrs. \_\_\_\_ 9. BIRTHPLACE (city or town). (State or country) CONTRIBUTORY ..... (Secondary) 10. NAME OF FATHER ......(duration) .....yrs, .....mos. 18. Where was disease contracted if not at place of death ? 11. BIRTHPLACE OF FATHER (city or (State or Country) Did an operation precede death Date of .. Was there an autopsy?..... 12. MAIDEN NAME OF MOTHER What test confirmed diagnosis should (Signed) 18. BIRTHPLACE OF MOTHER (city or tow (State or County) WRITE PLAI N. B.—Every Date of Burial 19. Place of Burial, Cremation, Informant (Address) Address Begistrar.

STATEMENT OF OCCUPATION.—Precise statement of o supation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive Engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used on'y when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Saleman, (b) Grocery: (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer." etc. without more precise specifications, as Day laborer. Farm laborer, Laborer-Coal Mine etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children not gainfully employed, as At school or At Home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 vrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH(the primary affection with respect to time and causation), using always the same ac-

cepted term for the same disease. Examples: Cerebro spinal fever (the only definite synonym is "Epidmic cerebrospinal meningitis"); Diptheria (avoid use of "croup"); Typhoid Fever (never report Typhoid pneumonia"); Lobar Pneumonia; Bronchopneumonia ("pneumonia," unqualified, is indefite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of ...... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping Cough; Chronic valvular heart d'sease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age." "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL Septicemia." "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning: struck by railway train-accident; Revolver wound of head-homicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull and consequences (e.g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of each death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.